

DOCUMENT RESUME

ED 248 643

EC 170 421

TITLE The Maine Approach: A Treatment Model for The Intellectually Limited Substance Abuser.

INSTITUTION Kennebec Valley Regional Health Agency, Waterville, ME.; Maine State Dept. of Mental Health and Mental Retardation, Augusta.

PUB DATE 84

NOTE 137p.

AVAILABLE FROM Mental Retardation Alcoholism Project, KVRHA, P.O. Box 728, 8 Highwood St., Waterville, ME 04901 (\$3.50).

PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC06 Plus Postage.

DESCRIPTORS *Agency Cooperation; *Alcoholism; Coordination; *Drug Abuse; *Mental Retardation; *Program Development; *State Programs

IDENTIFIERS *Maine

ABSTRACT

The document presents Maine's model for providing substance abuse treatment to the client with mental retardation. Introductory information on retardation and substance abuse is followed by a discussion of this population's unique problems. Services offered in the Mental Retardation Alcoholism project are reviewed, and contracts and cooperative service agreements are viewed as approaches to improve interagency relationships. Staff training programs are outlined, including guidelines for assessment, treatment, and aftercare. Case studies illustrate the joint planning process and possible outcomes of intervention. Extensive appended material is organized according to material for the system (such as service contracts), assessment process (including the interviewing questionnaire), and treatment and aftercare (including guidelines to behavior modification and educational consideration). (CL)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

ED248643

THE MAINE APPROACH

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

- ☒ This document has been reproduced as received from the person or organization originating it.
- ☐ Minor changes have been made to improve reproduction quality.
- Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

David N.
Fenton

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

A TREATMENT MODEL FOR THE INTELLECTUALLY LIMITED SUBSTANCE ABUSER

EC 170421

**THE MAINE APPROACH
A TREATMENT MODEL FOR THE
INTELLECTUALLY LIMITED
SUBSTANCE ABUSER**

**A COOPERATIVE EFFORT BY
THE MAINE DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION
KEVIN W. CONCANNON, COMMISSIONER
AUGUSTA, MAINE
AND
THE KENNEBEC VALLEY REGIONAL
HEALTH AGENCY
DAVID N. FENTON, DIRECTOR
WATERVILLE, MAINE**

Printed Under Appropriation 4340.2

1984

COPYRIGHT 1984 Bureau of Mental Retardation, Maine Department
of Mental Health and Mental Retardation

FOREWORD

For some years and during the past six years in particular, Maine has been following a course of service development and humane de-institutionalization for mentally retarded persons that has become recognized nationally. This effort, which has demanded persistence and hard work from our staff and cooperation from local citizens and public and private agencies, has allowed our mentally retarded fellow citizens to live and work in the community with dignity and with the freedom their individual disability will allow. The courage of mentally retarded persons and the support and acceptance of the communities, neighbors and families has been an inspiration to all who have been part of the process.

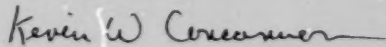
Community living for mentally retarded people who had sometimes spent years in an institution presented the state with demands for new and different services. The development of congregate housing, independent living facilities, respite care homes and alcohol/substance abuse programs emerged as new opportunities and challenges for a statewide system of care and support.

In the process developing community living programs, service providers, families, participating agencies, and the staff of the Bureau of Mental Retardation found that the mentally retarded person suffers the same trials and tribulations that other citizens encounter in a free society. Free people sometimes become involved in the use and misuse of alcohol and other mind altering substances. The problem of dealing with alcohol and substance abuse in the mentally retarded citizen was further compounded by our realization that expertise in alcohol/substance abuse and expertise in mental retardation programs are seldom found in the same professional. These two facts provided the basis for the program presented in this document. The program is the culmination of a lot of hard work pursuing a vision shared by many people. A vision that hopefully will provide a solution to just one of the challenging problems emerging from the state's efforts to place mentally retarded citizens from our institutions in the community.

The Department of Mental health and Mental Retardation would like to acknowledge those whose creative thinking and dedicated support provided the basis for this project. The Maine Legislature's Joint Select Committee on Alcoholism Services and particularly the Co-Chairpersons of that committee Senator Beverly Bustin and Representative Neil Rolde, were extremely helpful in initiating this project. Special thanks are extended to Governor Joseph Brennan who has continually demonstrated his desire to provide appropriate care for Maine's mentally retarded citizens both in our public institutions and throughout the State of Maine in various community programs. The efforts reflected in this report are but an additional reflection of the improvement and development of needed care and treatment for this long-neglected population.

I am confident these efforts are making a difference for Maine people.

With Best Wishes,



Kevin W. Concannon, Commissioner
Maine Department of Mental Health
and Mental Retardation

ACKNOWLEDGEMENTS

The Mental Retardation Alcoholism Project and the Department of Mental Health and Mental Retardation would like to thank the following people for their contributions in the planning and development of this model:

Mental Retardation Alcoholism Project - Advisory Council

Bruce Libby - BMR Central Office

James Pierce - Independence Association for Retarded Citizens

Griffith Mathews - Crossroads

Ralph Kilgore - Southern Regional Alcoholism and Drug Abuse Council, Inc.

Jamie Morrill - Department of Mental Health & Mental Retardation

Thomas Bancroft - Department of Human Services

Marianne Shirley - BMR II

Ronald Welsh - Department of Mental Health & Mental Retardation

Susan Dale-Hall - Mental Retardation Alcoholism Project, Kennebec Valley Regional Health Agency

Other Contributors

Rita Clark - BMR V

Kathleen Hammond - BMR IV

Kent Simondinger - BMR III

Jerry Bouchard - BMR III

Julie Sipser - BMR III

Marilyn Thayer - BMR VI

Carol Ramm - BMR II

Barbara McVety - New Directions

Ellen Akins - Tri-County Mental Health Center

Charlie Smith - Community Alcoholism Services

Laura Levinson - Bangor Halfway House

Jerri McQuillan - Kennebec Valley Comprehensive Alcoholism Treatment Program

Gil Whitney - Hope House

Ann Harrington - Hope House

Richard Corbett, M.D. - Kennebec Valley Comprehensive Alcoholism Treatment Program

Lorraine Zinck - Tri-County Mental Health Center

Bob Kenney - Fellowship House

Joey Wallace, BMR - IV

The Association of Regional Councils

Maine Association of Substance Abuse Programs

TABLE OF CONTENTS **TREATMENT MODEL** **FOR THE** **INTELLECTUALLY LIMITED SUBSTANCE ABUSER**

I. The Population in Need	1
A. Demographic Data	1
B. Therapeutic Needs	3
C. Barriers to Treatment	5
II. A Model for the System	7
A. Description of the Current System	7
B. Mental Retardation Alcoholism Project	8
C. Contracts	9
D. Cooperative Service Agreements	10
E. Planning New Services	10
F. Program Linkages and Service Integration	10
G. Evaluation of Services	11
H. Training	11
III. A Model for the Client and Direct Service Providers	12
A. Assessment Interviewing	12
1. Determine if the Referred Individual is a Client of the Bureau of Mental Retardation	12
2. Involve the Client Service Coordinator and any Other Community Resources	12
3. Refer the Client for a Medical Evaluation	13
4. Refer some Clients for a Psychological Evaluation	13
5. Ask for Feedback from the Client	14
6. Assess the Most Appropriate Method of Treatment	14
7. Resolve the Issue of Primary Diagnosis	15
8. Beware of Distorted Diagnostic Impressions	15
B. Treatment Process	16
1. Identify a Primary Counselor	16
2. Identify a Primary Case Manager	17
3. Work Closely With BMR	17
4. Develop a Relationship with the Client	17
5. Build in a Reward System	17
6. Avoid Overprotecting the Client	18
7. Deal with Scapegoating by Other Clients	18
8. Determine the Client's Appropriateness for Group Therapy	18
9. Provide a Link with Substance Abuse Treatment and the Community	18
10. Identify an Authority Figure for the Client	19

11. Restructure Length, Frequency and Pace of Treatment ..	19
12. Provide the Client with a Specific Structure	19
13. Develop Contracts with the Client	20
14. Assist the Client in Locating an AA Sponsor	20
15. Insure a Solid Link with the AA Community	20
16. Provide a Specialized Education Program	20
C. Aftercare Process	21
1. Maintain Involvement with Other Care Providers	21
2. Develop an Aftercare Plan which is Consistent with the Client Needs	21
3. Build in a Reward System	21
4. Provide the Client with a Structure	22
5. Provide Training to Other Support Systems Involved in Aftercare (e.g., Residential Center Staff)	22
D. Case Studies	22

APPENDICES

A. For the System	
1 . Service Contract	29
2 . Cooperative Service Agreement	33
3 . Flowchart of Program Linkages in Case Planning	35
4 . Training Outline	36
B. For the Assessment Process	
1 . Interviewing Questionnaire	40
2 . Caseworker Questionnaire	46
3 . List of Questions to Ask the Psychologist	48
4 . Differences between Mental Retardation and Mental Illness	49
5 . Possible Indicators of Deficits in Intellectual Functioning	50
C. For Treatment and Aftercare	
1 . Express and Informed Consent	52
2 . Definitions of Case Management	54
3 . Guidelines to Behavior Modification	55
4 . Preliminary Treatment Plan	89
5 . Secondary Treatment Plan	92
6 . Aftercare Plan	93
7 . Client Contracts	94
8 . Reward System	95
9 . Educational Considerations	97
10 . Making Your Own Educational Materials	98
11 . Alternative Methods for Presenting Materials	99
12 . Adaptable Materials	99
D. Resources	
1 . Definitions	101
2 . Types of Services for Mentally Retarded People	108
3 . "Rights of the Mentally Retarded"	110
4 . Bibliography	119

THE POPULATION IN NEED

Providing substance abuse treatment to the client with intellectual limitations is a relatively new process for most health and human service professionals. They have had little experience in identifying, assessing, and treating the intellectually limited client and what experience they have had left them feeling inadequate and frustrated. A good part of these feelings is a result of not knowing about the limitations and capabilities of this population. The following section describes the intellectually disabled client and is divided into three sections - demographics, the therapeutic needs and barriers to treatment.

A. Demographic Data

The term "mental retardation" is very broad and is used in many different ways by many people. The American Association of Mental Deficiencies states that "Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period." "Significantly subaverage" means having an IQ of 69 or below and "the developmental period" is before the individual is 18 years old. In Maine, there are currently 2,795 mentally retarded individuals who are clients of the Bureau of Mental Retardation (BMR). Three hundred and thirty of these individuals reside in the Pineland center (1982). BMR has determined that there are 1,167 mentally retarded individuals on its caseload who fall in the moderately or mildly retarded categories. Individuals with moderate or mild retardation have an IQ between 40 and 69 (MIS, 1982). An additional 1,268 BMR clients have an IQ below 40 and are either severely or profoundly retarded.

In addition to those individuals served by BMR, the Department of Human Services estimates that there are an additional 66 individuals with marginal intellectual functioning (IQ of approximately 70 to 85) who are receiving services from its Division of Adult Protective Services. (To qualify for Adult Protective Services, an individual must be incapacitated or dependent and in danger and not mentally retarded.)

Currently, there are no precise means for measuring the number of individuals with intellectual limitations who are not clients of BMR or Adult Protective Services. However, national estimates suggest that 29,000 residents of Maine have a below average intelligence (IQ of approximately 85 and below). A large part of these people have very few resources, have lost the support of the families and live on the streets.

The focus of our plan will be placed primarily on those who fall in the mildly or moderately retarded category. Those people who have limited or marginal intellectual functioning may experience similar problems in receiving substance abuse treatment and will also benefit from services developed in the model. These individuals are apt to live in less restrictive environments and have greater access to alcohol and other drugs.

Substance abuse occurs when the use of alcohol or other drugs causes any kind of problem in the person's life, and he or she continues to use them. The Office of Alcohol and Drug Abuse Prevention uses the Marden method to estimate the number of problem drinkers in the State of Maine. It concludes that 5% to 8% of the general population abuse alcohol. (The Marden statistical method develops an estimate based on employment and age categories which may not adequately reflect substance abuse among mentally retarded individuals).

If we use the Marden statistical method and figure five percent to eight percent of 1233 ($1167 + 66$) we find that 61 to 98 of the individuals who receive BMR or DHS services abuse alcohol and other drugs. This method (5% to 8% of 29,000) gives us an estimate of 1,450 to 2,320 individuals with below average intelligence who are substance abusers in Maine.

Many professionals in the fields of substance abuse treatment, mental retardation and mental health believe that these estimates are too low. Some intellectually limited individuals experience low self-esteem, loneliness and repeated failures which may contribute to increased alcohol abuse. They are continually being told that they are different and do not fit in with non-mentally retarded people. The fellowship found in a local tavern where alcohol serves as an intellectual and social equalizer, may provide comfort and refuge from the isolation. This may be particularly true for those who have limited intellectual functioning but are not mentally retarded. Bella Selan, coordinator of outpatient psychiatric services to mentally retarded adults, and author of "In a Bar, Retarded Persons are Idiots No More", states that "persons who have IQs of 70 to 85 are precisely the ones who know how 'different' they are. They suffer the most from increased frustrations, psychological stress, social inequality and stigmatization. Because stress and conflict are ameliorated by the use of alcohol, we should not be surprised to discover that the borderline retarded person may be the most attracted to drinking and bars" (Selan, page 2).

Another factor which may predispose intellectually limited people to

abuse is that people with mental handicaps may have medications prescribed as treatment for some aspect of their disability. As people develop the habit of using medications, alcohol has the potential for becoming one more drug to control pain or moods. For these people, the danger posed by the use of alcohol may be far greater than for other individuals because of its interaction with other medication. The combined effects may far exceed the effects experienced by using either the alcohol or the medication independently (NIAAA, 1977).

B. The Therapeutic Population

Intellectually limited substance abusers experience many of the same problems as the substance abuser of average or better than average intellect. Internally, they may feel guilty, hurt and afraid while externally they demonstrate rigidity, charm, aggression, and anger. Alcoholism and other drug abuse affect their jobs (and ability to get a job), their family and peer relationships, and their self-esteem. Many have problems with the law, abuse health and social services and tend to be very streetwise. Their problems with alcohol and other drugs, like those of the client with average intelligence, affect all aspects of their lives.

It is very difficult to generalize about this population. People with intellectual limitations, however, demonstrate certain features which are more common to them than to others. The most salient characteristics are their reduced intellectual functioning and their poor social adaptive behavior. All other features outstanding to them are a result of these characteristics.

Some of these descriptions are easily recognizable by the lay person. For example, because they are slower intellectually, it takes a longer period of time for the mentally retarded person to comprehend information. This concept has implications for all phases of the treatment process, particularly as it relates to length of treatment, number of meetings, and pace. It also suggests that the counselors need to adjust their own expectations for the client's level of functioning.

The intellectually limited person tends to more readily understand immediate and concrete feedback. Substance abuse treatment, on the other hand, focuses on delayed gratification. The message in substance abuse treatment is that treatment is not easy or fun, nor is early sobriety, but if the clients are patient and work hard, their lives will eventually become better. Most intellectually limited people do not understand that concept. It is crucial that substance abuse treatment providers be aware

of the need for timely reinforcement when serving an individual with intellectual limitations. Furthermore, substance abuse treatment providers must be aware and deal with the fact that the client will always be limited intellectually.

The inability to process certain kinds of information can also be the result of lower intellectual functioning. Counselors may find this problem to be the greatest challenge. First, it affects a crucial decision in the assessment stage of treatment. Is this client in alcoholic denial or is the client simply not understanding the information? The lack of comprehension also makes it more difficult for counselors to assess how much of the alcoholism treatment information and education will be understood by the client.

An associated and complicating factor is the "parroting" trait of some mentally retarded people. When they feel the need to be accepted, they say what they think you want to hear. They are often more used to performing to someone else's expectations rather than their own. Therefore, if the counselor asks if the client understands and the client nods "yes", this may be a parroting statement. The client may not truly understand.

Generalizing information is another intellectual process which is difficult for many mentally retarded people to achieve. Most people of average intelligence learn from their life experiences and then apply those lessons to new experiences. An intellectually limited person does not necessarily have this ability. For example, a mentally retarded client learns in treatment that she deals with anger towards her husband by going to drink at a local bar. In treatment, she role plays other ways of dealing with her anger towards him. After leaving treatment, the woman gets angry at her girlfriend and deals with it by going down to drink in the bar. This is only one example of many where elements in the environment change and the intellectually limited person is unable to make generalizations.

Intellectually the clients with mild mental retardation and substance abuse problems tend to be at an early adolescent "mental age," a time in which abstract reasoning abilities are just beginning to develop. Knowing the implications of their actions is difficult to those who may not have this ability. Instead, most mentally retarded people tend to understand black/white logic and tend to be very concrete thinkers.

Some intellectually limited people have what is termed as a "selective memory." They hear a lot of information but they remember only one part of that information. At times, the client may get stuck on that one

thought. For example, one client became involved in the AA program and quickly picked up the concept of a Higher Power. Unfortunately, the client was not able to grasp the other concepts that go along with it. "The Higher Power keeps us sober so that we may be responsible..." He felt that the Higher Power would take care of every part of his life. His reasoning was that he did not have to work because his Higher Power would take care of him. If he drank away his money, the Higher Power would find him food, etc. Clearly, this represents an area where counselors must be cautioned. Early recognition that the client is focused on only one piece of information will give the counselor a better chance at correcting it.

Perhaps the clearest means of describing the mentally retarded substance abuser as a group is that their retardation causes them to be slower developmentally in understanding and in resolving their problems. The lack of intellectual and service resources combined with limited reasoning abilities allow their problems to escalate and to affect virtually all aspects of their lives.

Finally, although not unique to this population, there is another factor which deserves special consideration. Mentally retarded people often have other handicapping or medical conditions in addition to their intellectual handicap. These are disabilities which may require medication for control. Combining alcohol and prescribed medications can present some very life threatening situations, while taking an individual off those medications can be equally harmful.

C. Barriers to Treatment

People with intellectual limitations who are also substance abusers constitute a unique and problematic population. Yet, very little has been done to learn how many individuals have both disabilities, whether they are able to get into substance abuse treatment, and whether they benefit from it. The experience of Maine's health and human service professionals demonstrates to us that there are barriers to treatment for this population. Although intellectually limited people have many of the same problems as substance abusers with an average intellect, their problems and needs are compounded as a result of their lack of resources, both structurally and intellectually.

Both organizational and attitudinal barriers keep the intellectually limited substance abusers from obtaining adequate treatment. Perhaps the most glaring problem is that of the "double-bind" inherent in the

system. Mental retardation service providers know little about substance abuse problems and feel that substance abuse treatment programs should deal with the problem. Likewise, substance abuse specialists do not know about mental retardation and believe treatment should be wholistically the responsibility of mental retardation service providers. Historically, these two fields have experienced very little cross pollination. The lack of communication clearly presents problems for the substance abuser with intellectual limitations in obtaining adequate treatment.

The two fields have also been responsible for providing their own staff training programs, educational development (for clients and staff), and program review and evaluation. Until now, there has been little or no formal recognition that there is a problem for the mentally retarded substance abuser. Therefore, both fields of service have not felt the need to cross organizational boundaries.

Attitudinally, however, the problem goes far beyond the organizational barriers. Because of the nature of each disability, neither field wants to work with the other's client. The lack of familiarity with the disabilities make them undesirable. Fortunately, these attitudes are slowly changing towards a more positive outlook as providers are learning and understanding the disabilities.

Philosophies regarding the best means of treatment vary among disciplines, as well as among programs and people within programs. Some believe that overprotecting the client enables the progression of the disease of alcoholism, while others feel that strong confrontation is not appropriate for the mentally retarded person. Others believe that the mentally retarded substance abuser is not able to be rehabilitated or that such an enormous amount of staff time and expertise is needed to deal with the multitude of problems, that providers are incapable of serving their needs. The conflicts in philosophies about different ways of dealing with a mentally retarded substance abuser make it very difficult to have consistent and coordinated efforts. As the client moves from one phase of treatment to the next, the mixed messages sent to him or her could be a deterrent in the individual's willingness to enter or to follow through the treatment process.

The problems confronting the intellectually limited substance abuser have, at times, felt overwhelming. However, as their limitations and capabilities are further defined, providers are having new insights into alternatives for their treatment. No longer are we asking how the client can adapt to the program, but how the program can adapt for the client.

A MODEL FOR THE SYSTEM

This section focuses on the structure and administration of services within the system. It offers an overview of what services are available in Maine (Description of the Current System and the Mental Retardation Alcoholism Project), their relationships and ways of improving those relationships (through Contracts and Cooperative Service Agreements), and the responsibilities of the system to provide administrative tasks which are consistent with one another (Planning New Services, Program Linkages and Service Integration, and Evaluation of Services). Finally, this section discusses the need for training at all levels so that providers have a basic understanding of philosophical, administrative and treatment differences.

A. Description of the Current System

There are numerous resources which can be utilized in treating the intellectually limited substance abuser. Specialists in alcoholism and drug abuse, mental retardation, adult protection, psychology, psychiatry, medicine, housing and employment of the handicapped, all deliver services for part of the individual's needs.

Substance abuse treatment serves clients in many different ways. For example, residential treatment can be hospital based or a free-standing facility. Outpatient services are delivered at correctional centers, mental health centers or, again, at free-standing facilities. There are special programs for adolescents, women, men, late-stage alcoholics and employees. Some programs focus on alcoholism as a disease; others focus on self-medicating or symptomatic abuse. All of these programs have in one way or another benefited an intellectually limited client.

The Bureau of Mental Retardation assumes responsibility for the development of many of the programs for the mentally retarded population. These services range from case management, sheltered workshops, transitional living programs and numerous housing options. Primarily, these programs are operated by private non-profit agencies and are independent of the management of BMR, with the exception of case management. These programs have varying levels of supervision and programming depending upon the level of client functioning.

Adult Protective Services (APS) of the Department of Human Services provides services for clients who are incapacitated or dependent and in danger, but not mentally retarded. APS primarily offers case manage-

ment for their clients who remain clients as long as they are in danger. Some of the clients they serve are intellectually limited, but they do not serve those who are mentally retarded. (In other words, they serve the intellectually limited adults who have an IQ over 70). The Bureau of Mental Retardation provides the adult protective services for mentally retarded people (70 and below).

These three fields have traditionally operated independently of one another, both administratively and programmatically. Communication between them has been poor. Although referrals may have been made from one to another, very little joint care has been provided. In fact, these fields have had little opportunity in the past to learn of the other's services and, therefore, an even greater distance is placed between them.

Other services, such as psychological and medical services, are highly depended upon by services that care for the intellectually limited and the substance abuser. Many of these services are provided through consultative or contract means. Other programs have them as a regular part of their program's services. For example, some regional BMR offices have a psychologist on staff and other offices contract with private psychologists in the community.

Other services, such as housing, food, transitional living, vocational development and employment, are usually sought from the community. These services are most often independently operated, and are not a part of APS, BMR or substance abuse treatment facilities.

A chart of services and their interaction is included in the manual.

B. Mental Retardation Alcoholism Project

The Mental Retardation Alcoholism Project was designed to enhance the ability of existing systems to provide treatment to the mentally retarded substance abuser. At the onset of the Project, it was clear that the mental retardation system was unable to habilitate someone who drank abusively. At the same time, substance abuse treatment programs had little knowledge of working with the intellectually limited client. The lack of communication between the two systems was identified as a primary area which could be improved by the Project.

The first year of the Project focused on a needs assessment involving many different health and human service professionals. Forums were held to gather information based on the experience of these professionals.

The forum participants identified the problems, options, resources and training needs in Maine. These forums also created an environment in which communication could occur between the various disciplines.

Training programs were conducted for both mental retardation and substance abuse service providers. Some units focused on assisting the mental retardation workers in identifying individuals who require referral for alcohol related education or treatment, and on how to expedite the referral process. In addition, alcoholism treatment staffs were trained on the needs and capabilities of the mentally retarded individual. Additional training focused on: working together in the treatment planning and in the treatment program; poly-substance abusers in treatment; and utilizing a combination of treatment methods to best serve each client's needs.

Throughout the course of the Project, the Coordinator has provided consultation to mental retardation and substance abuse treatment providers, largely based on information gathered at the forums. The Coordinator provides consultation at all levels of care:

1. Identification and Referral
2. Assessment Interviewing and Treatment Planning
3. Treatment
4. Aftercare Planning and Follow-Through

The Coordinator serves as a liaison between programs to promote communication, to help work out problems and to develop individualized treatment and aftercare plans. When the need for special services occurs, the Coordinator works with community and agency resources to develop the needed service. In those areas where there is a strong hesitancy to work with the mentally retarded substance abuser, the Coordinator works with the programs to advocate for the client and to improve the attitudes of service providers in working with this population.

Evaluating the client's progress is another function of the Coordinator. This involves meeting regularly with providers of substance abuse treatment and mental retardation services, contacting support services and preparing reports. It also involves tracking the client through treatment, into aftercare and documenting the progress.

C. Contracts

Contracts should be developed between substance abuse treatment

providers and mental retardation service providers. The contracts serve many purposes which benefit both the parent or State agency and the service providers. First, the contracts define the responsibilities of the administration and the treatment staff. Secondly, the contracts provide a mechanism by which information can be exchanged and data collected. Therefore, services can be monitored and evaluated as they are being developed and implemented. Finally, the contracts can provide a mechanism for the reimbursement of services for clients who do not have a third party payor. A sample contract is enclosed in the manual.

D. Cooperative Service Agreements

Cooperative Service Agreements between mental retardation service providers and substance abuse treatment providers offer many of the same benefits as the contracts. Since the exchange of information and the delegation of responsibilities are relatively new processes between these programs, the Agreements are a simple and clear means of defining these services, individual and shared. A sample agreement is enclosed in the manual.

E. Planning New Services

More and more, the need for new and specialized services is being identified as necessary for adequate treatment to occur. There is a need for ongoing identification of needs and continued planning at all levels: the State, the programs' administration and direct care. This requires that the State look at how resources are being allocated. Administrators must examine how they can plan for service integration, and direct care providers must work together in treatment plan development. The substance abuse treatment providers and the providers of services for the intellectually limited must work cooperatively so that these services can first be defined and then developed. Only a joint effort at all three levels will insure that the needs of the intellectually limited substance abuser will be met.

F. Program Linkages and Service Integration

The intellectually limited substance abusers are multi-need clients whose problems are not clearly compartmentalized. No single agency or program can adequately serve these clients. Traditionally, the programs for intellectually limited population and those for substance abusers have worked in two different spheres. Program linkages and service integration are essential to reduce fragmentation, inaccessibility and the discon-

tinuity. Some alternative ways of integrating services are included in the manual.

G. Evaluation of Services

The mental retardation service system and the substance abuse treatment system have, in the past, independently evaluated their own services. Assessing the effectiveness in both fields is a relatively new process in which expectations are just beginning to be developed. As evaluation processes are being developed, services for the mentally retarded substance abuser should be included in both treatment systems.

H. Training

Staff training programs have been designed in the past for both fields of substance abuse treatment and mental retardation. New and seasoned providers are acutely aware that continuing education is crucial if they are to keep abreast of new developments in their fields. These fields, however, have not provided cross training to each other. Mental retardation service providers should be trained to identify substance abuse problems and to make timely and appropriate referrals. They also should be trained to be actively involved in the treatment planning, the process and the aftercare. Substance abuse treatment providers need to become aware of the rights of the mentally handicapped, the nature of mental retardation and strategies that can be used in the rehabilitation of substance abusers who are intellectually limited. There is an enormous need for training which focuses on the population of intellectually limited people who live "on the streets." These people usually do not have families, employers, landlords or non-drinking friends who care about them. The success of current substance abuse treatment often rests on the leverages imposed by these concerned persons. New ways of intervening, treating and creating supportive follow-up care is going to be instrumental in developing the ability of treatment providers to work with this population.

It is also important for administrators and policy-makers to be made aware of the needs of the intellectually limited substance abuser. Their sensitivity to the problems and treatment needs will improve their ability to make resource allocations, to plan for new services, to integrate their services with other programs, and to evaluate their programs' effectiveness, all of which will impact on the total care of the intellectually limited substance abuser.

An outline of staff training programs is included in the manual.

A MODEL FOR THE CLIENT

This section of the model is designed to give information which substance abuse treatment providers can use in all phases of the treatment process. The intention is not to provide a "cookbook" for the treatment of the intellectually limited client, but rather guidelines and suggestions for developing a treatment strategy that responds to each client's needs.

A. Guidelines to the Assessment Process

The assessment process for determining the extent of substance abuse problems serves many purposes. First, the counselor can evaluate how far the disease has progressed or if the abuse is situational. Secondly, the counselor can determine what other needs the client has in addition to substance abuse treatment. Finally, it provides an opportunity to gather information about the specific treatment needs of the client. The assessment process is a critical first step in treatment planning. Below are guidelines which address the problems in doing a substance abuse evaluation with a mentally retarded person.

• Determine if the Referred Individual is a Client of the Bureau of Mental Retardation

It is very important to know whether the referred individual is a client of BMR so that they can be involved in the planning process. Many people feel uncomfortable asking someone if he or she is mentally retarded. One way is for the counselor to ask if the client receives help from any other programs or if the individual has a caseworker. If the referred individual is a BMR client then the counselor should contact the regional office. A list of BMR regional offices is included in the manual. If the counselor finds that the referred individual is not a client of BMR, the client should be asked whether or not they want BMR to be contacted. Then the counselor should determine what characteristics indicate that this individual is mentally retarded (see examples in the manual). The counselor should contact the Mental Retardation Alcoholism Project Coordinator with this information.

• Involve the Client Services Coordinator (CSC) and Any Other Community Resources in the Assessment Process

In order for the evaluation to be useful, the counselor must gather an enormous amount of information from the client and the family. For a

number of reasons, including the defenses of a substance abuser, poor memory retention or a desire to please, the information given by a mentally retarded client is not necessarily reliable. It is to the counselor's advantage to involve as many people as possible, particularly the BMR Client Services Coordinator. They can assist in gathering necessary historical information relating to the client's drinking, information regarding the client's level of functioning, and factors that may serve as motivators for the client. If the client is not a BMR client, then any other community resource, such as APS or Vocational Rehabilitation, should be asked to participate.

- **Refer the Client for a Medical Evaluation**

All clients should be referred for a medical evaluation if they have not received one in the past year. For the client with mental retardation, this process should involve an extensive evaluation of any other handicapping condition. For example, 40% of the mentally retarded population is estimated to have seizure disorders in conjunction with the mental retardation. A drug commonly used to treat seizure disorders is Dilantin. If the client has stopped taking the medication or has been drinking heavily (which can cancel the therapeutic value of the medication), the client is in serious risk of having seizures. The doctor, client, family, CSC, and counselor need to be aware of this risk. The medical evaluation should also determine whether the client is stabilized on the medication. Additionally, the counselor and caseworker must begin to educate the client about the use of prescribed medication and the hazards of combining alcohol and medication.

- **Refer Some Clients for a Psychological Evaluation**

When determining whether the client should have a psychological evaluation, this question should be asked: "What information do I need from the evaluation?" If the evaluation is needed to determine the nature of bizarre behavior, the ability to understand abstract reasoning or the possibility of concurrent mental illness — then the evaluation may be a valuable tool. However, it is important to keep in mind that, even though the evaluation can be useful, it may also cause the clients to wait more than ten days before they are able to enter treatment. The time between the decision to enter a treatment program and actually being admitted is difficult for all clients but is particularly hard for the mentally retarded person who has fewer resources to rely on for support.

If the counselor determines that the psychological evaluation would pro-

vide useful information, he/she should first contact the client's caseworker (CSC) to find out if there is a **current** evaluation on file. If not, the CSC may be able to assist in getting a timely psychological evaluation. If the individual is not a BMR client, a referral should be made to a local mental health center, to a private psychologist, or to a psychologist on the substance abuse program's staff. (This may be the most efficient and least stigmatizing for the client). The substance abuse counselor must be prepared to tell the psychologist exactly what specific information is needed. Many times a psychological evaluation is done and only an IQ is determined. This, clearly, is not useful information for the substance abuse counselor.

- **Ask For Feedback From The Client**

One of the most revealing components of the assessment process is the verbal exchange. The counselor has the opportunity to find out if the client demonstrates symptoms of the disease such as denial, rigidity, charm or other defensive mechanisms. The mentally retarded client may not have well developed verbal skills. The "parroting" trait and the compliance of many mentally retarded people complicate the ability of counselors to get a clear understanding of the symptoms. The counselor should not only ask the client questions more than once, but it has proven more successful to ask the client the same question in different ways. Counselors will also need to ask the client to "repeat back to me, what I just said to you, using your own words," giving the counselor a better idea of the client's level of understanding. The CSC may be able to provide information on the client's degree of compliance and how the client demonstrates the compliance. In some cases, the CSC may be aware of blackouts that the client has experienced.

- **Assess the Most Appropriate Method of Treatment**

Throughout the assessment process, the counselor is evaluating the extent of the disease's progression and in that process, determining the most appropriate and least restrictive method of treatment, and assessing the client's ability to function in AA and what assistance might be needed to improve the client's use of the AA program. Factors involved in deciding whether the client needs residential or outpatient treatment include: the need for continuous, uninterrupted flow of treatment; the likelihood of danger to the client or others if the client continues to be exposed to chemicals; history of prior treatment; and the need for detoxification. Many mentally retarded people present at least two of these factors and, therefore, would need the added support from residential

treatment. Since people with mental retardation may not always be able to fully participate in residential treatment, the counselor is faced with a decision using conflicting evidence. In the following section on treatment is a discussion of treatment process alternatives. The basis for the decision rests on the ability of the program to be flexible and to provide alternatives in residential treatment, or whether other resources are available if the counselor recommends outpatient treatment.

Sometimes neither of these conditions exist. For example, a client may present such deficits in intellectual functioning, that the counselor determines he or she would not benefit from the highly verbal insight-oriented structure of residential treatment, even with adaptations in the program. At the same time, community resources are not appropriate or available for the client. If a counselor is faced with this double bind, the Project Coordinator should be contacted to assist in developing an appropriate alternative.

- **Resolve the Issue of Primary Diagnosis**

One of the largest barriers for the mentally retarded alcoholic is a philosophical one. Even though it is the position of the Department of Mental Health and Mental Retardation that both disabilities must be addressed, what occurs out in the field can be very different. Both disabilities are seen as primary by their perspective fields. Each is a chronic, lifelong handicap which affects virtually all aspects of their lives. The problem rests in the battles over who should serve the client (the implication is that they be served by one or the other). Mental retardation service providers are not trained to deal with substance abusers. Alcoholism and drug treatment providers also do not know about mental retardation. However, some providers are now realizing that it is not a matter of who will "dump" the client on whom, but rather that the client needs **both** services for either one to be effective.

- **Beware of Distorted Diagnostic Impressions**

Perhaps the greatest caution for the counselor is regarding a distorted diagnostic impression because of the mental retardation. Levitan, Reiss and Szyszko report that "Intellectual subnormality is such a salient aspect of mental retardation that emotional problems tend to be overshadowed in importance and attributed to retardation rather than psychosocial history." (1982) (A Bibliography is included in the manual). The client's caseworker (CSC) or a BMR Community Program Consultant are available to help the substance abuse provider sort out which problems are the result of the individual's emotional and social history.

Philosophies regarding treatment of the mentally retarded substance abuser vary among treatment providers. The conflicts in philosophies about different ways of dealing with a mentally retarded substance abuser make it very difficult to have consistent and coordinated efforts. Many providers are uncomfortable when working with a mentally retarded person. This fear is often attributed to a lack of knowledge of how to communicate with someone who is mentally deficient. The special needs of some people with limited intellectual functioning may create a very complex task for substance abuse treatment providers. The mentally retarded person may need specialized communication techniques, varied educational methods, or new therapy alternatives. Providers may feel overwhelmed, which again contributes to the hesitancy in providing services for this population. When presented with a mentally retarded client, the substance abuse counselor should take the time to examine his/her own feelings about the mentally retarded client. Establishing that awareness will help the counselor to remove his/her own biases while doing a clinical evaluation and making recommendations. Mental retardation service providers should also be encouraged to evaluate their feelings about their substance abusing clients.

B. Guidelines for the Treatment Process

Throughout the first year of the Mental Retardation Alcoholism Project, a great deal of information has been gathered about what kinds of things do work and what kinds of things do not work in treatment. Below are suggestions which can be applied within the structure of existing treatment programs.

- **Identify a Counselor Who is Comfortable in Dealing with the Intellectually Limited Client**

When a client is first referred to the program, the treatment providers should assess which counselor is most qualified to serve that particular client's needs. Not many counselors have experience in working with mentally retarded substance abusers. There are providers, however, who feel more comfortable in dealing with mentally retarded people. A better attitude will help to reduce the frustrations of the counselor and client, increase the caring and concern for the client, help the counselor in setting more realistic expectations of the client's progress and aid the counselor in setting realistic treatment goals for the client.

- **Identify a Primary Case Manager**

If the individual is a client of BMR, then the CSC will continue to be the primary case manager. However, if the individual is not a BMR client, then the counselor and the community service providers should identify one person who will take the responsibility. A description of the case manager's role is included in the manual.

- **Work Closely with the BMR/CSC and Other Social Support Systems**

Mentally retarded individuals may have many different health and social service providers giving them assistance in other areas - psychologists, caseworkers, vocational rehabilitation specialists, to name a few. These providers should be encouraged to participate in the treatment planning, case review, treatment process and aftercare planning.

- **Develop a Relationship with the Client**

Developing a rapport with the client is increasingly being realized as an important part of the substance abuse assessment and treatment process. In fact, a substance abuse counselor may not be able to complete a thorough assessment until after a client/counselor relationship has been established. A deep level of trust is created so the client is more apt to explore the inner pain, promoting the growth process. For the person with mental retardation, the benefits go beyond this. The relationship itself may be enough to inspire the client to stay sober. Clearly, this compliance can only last a short period of time, but that time may be enough to create some change. Norma Nelson of Family Counseling Service in Washington, reports that "approximately 80% of the (mentally retarded) clients show significant early benefit from counseling as a relationship is established... The client usually feels relieved to have a significant, close, supportive relationship that provides appropriate skilled guidance as well as deep respect and appreciation for him or her as a unique, valuable human being." (1983)

- **Build in a Reward System**

The mentally retarded person may not understand the concept of delayed gratification. Immediate reinforcements that are clear and realistic, both verbal and material, will give the client positive reinforcement that serves as a concrete motivator. This is particularly important because mentally retarded people may not have an expectancy of reinforcement on a day-to-day basis. Again, the caseworker may be able to help the counselor in

setting up a reward program which is meaningful to the client and will reinforce the client's responsibilities. The substance abuse counselor should work with the BMR caseworker and, if at all possible, all other providers who will be involved during treatment and aftercare. The counselor, caseworker and the team should first determine what serves as reinforcers for the client. Secondly, they must assess whether those reinforcers are appropriate for the client's age. Then, taking these two factors, the client's environment and the expected outcome, the team should develop a reward system. The Community Program Consultants are also available to "troubleshoot" when the providers feel lost as to which direction they might go with the client. An example of a reward system is included in the manual.

- **Do Not Overprotect the Client**

Some mentally retarded people will use their disability to manipulate others. They are very much aware of their intellectual limitations and will sometimes act more retarded than they actually are in order for people to protect and take care of them. Mentally retarded people are also subject to "scapegoating" by others. Substance abusers feel so much anger and pain inside themselves that they project those feelings onto the weakest people. Counselors have expressed concern that that situation often gives them conflicting feelings. Many times they do not know whether they should interfere and guard the client, or if they should remain impartial and allow the mentally retarded client to be scapegoated. Keep in mind that it is okay to discuss with the mentally retarded client about the way others are treating him or her.

- **Determine the Client's Appropriateness for Group Therapy**

Group therapy can be a productive model for the mentally retarded person. He or she can benefit from the support, feedback from group and the peer relationships often developed in a group. Before placing a mentally retarded person into group therapy, the counselor must determine the kind of group the client will be entering. Small, slower paced groups that have a greater emphasis on education than on insight tend to be more helpful for the mentally retarded client.

- **Provide a Link with Substance Abuse Treatment and the Community**

As we mentioned in the population description, the mentally retarded person sometimes is not able to make generalizations. Therefore, substance abuse treatment which is too narrowly focused will not become

meaningful unless the counselor demonstrates the connection between treatment and life in the community. The counselor can achieve this in a number of different ways. Outpatient counselors should be strongly encouraged to set up a special meeting in the residence or can visit the client's worksite. The counselor can also participate in showing the client social alternatives; for example, going for coffee or seeing a movie. Residential and outpatient treatment providers can ask friends or co-workers of the client to participate in free-time activities or as "concerned persons." If the client will be returning to a sheltered workshop or structured living, individuals from these settings can also participate in treatment.

- **Identify an Authority Figure for the Client**

The mental age of a mildly retarded person often places them in an adolescent developmental stage. They are adults and want to be treated as adults, yet, they often require structure and authority. The primary counselor should **not** be this person, but preferably someone outside the treatment system, a probation officer, home operator or CSC, for example.

- **Restructure the Length, Frequency and Pace of Treatment**

Outpatient treatment will be more effective if the length of the sessions are shortened to accommodate clients with a short attention span. Equally helpful is to increase the number of sessions per week. The client gets more support and the treatment issues are more frequently reinforced.

Counselors may need to slow down the pace of treatment and repeat information over and over. Remember, it may take longer for mentally retarded people to understand new information.

- **Provide Structure for the Client**

Like authority, the person with mental retardation needs structure. Follow a similar routine when opening the session, during the session, and in closing the session. At the same time, it is difficult for some clients to stay focused on the here and now. They may jump back and forth from past to future and from topic to topic. Pre-planning some of the sessions will help to alleviate the lack of focus. The counselor may need to be more directive than they are normally with the client of average intelligence. For example, a counselor could play an educational tape and then the client and counselor could talk about it staying focused on the

information on the tape.

- **Develop a Contract with the Client**

Writing a contract which specifically addresses an area of concern is a good way to have clear communication and commitment from the client. For example, you have asked a client repeatedly to be quiet while others are talking, yet the client continues to talk. A written agreement clearly outlines the consequences of his or her behavior. "The first time you talk while others are speaking, I will ask you to stop. If you continue to talk, you will be asked to leave the room." Contracts seem to represent more authority for the intellectually limited substance abuser, especially when it is on paper.

- **Assist the Client in Locating an AA Sponsor**

If it is determined that the intellectually limited client can benefit from AA, then the client must be introduced to an AA sponsor who will be willing to spend time orienting the client to the AA program. This would involve taking the client to meetings, explaining the meetings, introducing the client to other AA members and discussing the educational portion of AA. If the substance abuse providers have not already developed the AA contacts, they can make a request at their district or local meetings.

- **Insure a Solid Link with the AA Community**

AA has proven to be an integral part of the recovery process for intellectually limited clients if a solid link has been made with the program. Simply making a referral to the AA program is not enough. The intellectually limited client needs to have someone - a counselor, caseworker, AA member - who will provide transportation, take them to meetings, make introductions to other members, and initiate discussions with the client. Most intellectually limited people require extra guidance so that they can become comfortable with and understand the AA program.

- **Modify Your Educational Program to Fit the Needs of the Client**

Many mentally retarded people cannot read or write. Films and lectures are often presented at a level that exceeds that of the client. The counselor should do more verbal education, use materials with a visual presentation and use cassette tapes. Be aware that most of the cassettes on the market are also prepared for a higher functioning client.

Sometimes making a recording of your counseling session and giving it to the client to take with him or her, can be an excellent way of reinforcing information and educating the client. A list of adaptable educational materials is included in the manual.

C. Guidelines for the Aftercare Process

The Aftercare Process means many different things to different people. For our purpose, however, aftercare is referred to as a process which begins after the issue of substance addiction has been addressed. It is designed to provide the client with the support necessary to maintain sobriety, re-establish family relationships, become socialized and whatever else is needed to improve the quality of sobriety. The following section outlines some special considerations in the aftercare process.

- **Involve People Who Work or will be Working with the Client in the Aftercare Planning**

The aftercare planning process must be a collaborative effort with the client, the counselor, the BMR caseworker and any other health or social service providers. This effort is an essential part of helping people with retardation achieve a satisfying life within the community. The team must make sure that the case manager has been identified and is carrying out those duties.

- **Develop an Aftercare Plan Which is Consistent with the Client's Needs**

Substance abuse treatment specialists are generally very aware of the aftercare needs of a client as they relate to their substance abuse recovery. However, the mentally retarded client will most likely need an habilitation plan. (Habilitation is defined in the manual under "rights of the Mentally Retarded.") It is important that these two plans are consistent with each other. The substance abuse counselor, caseworker, and other supportive services should work closely to develop a wholistic plan which addresses the needs of the client.

- **Build in a Reward System**

It is equally important to implement a reward system into the aftercare plan as it is into the treatment process. The intellectually limited client needs to be reinforced in a timely and concrete manner. Becoming involved in a task which is meaningful to the client is one reward that has worked quite well. However, counselors and caseworkers must be aware

that there might not be an available meaningful task in the community. Sometimes there is a need for the professionals to create one.

- **Provide the Client with a Structure**

Again, the intellectually limited client often desires freedom but requires structure. An aftercare plan which is too flexible, and one that is highly structured and is packed with activities, both set up the intellectually limited client to fail. The planning team should develop a plan which is consistent with the client's capabilities. The case manager can monitor the client in the follow-through of the plan and if the plan needs adjustment, the team can be called together to discuss it.

- **Provide Training to Community Services for the Mentally Retarded which will be Involved in the Aftercare**

Many support services are not fully aware of issues surrounding substance abuse and treatment. These providers will be better equipped to be supportive if they are offered inservice training about substance abuse enabling and recovery needs. These programs could possibly be held at a residential center for the mentally retarded or at a sheltered workshop. Contact can be made through the regional BMR office, CSC or Program Operator.

D. Case Studies

Jerry is a 24 year old BMR client

I. HISTORY

A. Mental Retardation - Jerry is diagnosed as having moderate mental retardation. His reported degree of MR, however, is not reflected in his presentation of himself or his conceptual understanding. He is streetwise and relatively high-functioning. Jerry learned at an early age that doing well on his tests would mean that he would "lose his money" (SSI).

B. Family - Mother died when he was very young which left his alcoholic father alone to raise six children. His older brother, Patrick, was the first to introduce Jerry to alcohol and Valium. One sister is a continuous heavy user of Valium and her husband is also an alcoholic. Only one sister has been willing or able to provide a clean, healthy chemical-free living environment. This sister has been supportive of Jerry, but is also very soft-hearted and non-

confrontive. Jerry has taken advantage of this and over-run her household causing many problems within her family unit.

C. Medical - Jerry has had many hospital admissions associated with his drinking, both medical and psychiatric. Many times he would feel the need to "dry out" so he would call the ambulance and tell them he had also taken drugs. This ploy was necessary for him to be admitted. Jerry also had been diagnosed as having problems with his "nerves" and was prescribed Valium by a local doctor. Despite all this and his poor eating habits (associated with his drinking) Jerry has maintained relatively good health.

D. Arrests - His arrests include drunk and disorderly, shoplifting (usually steals vanilla or aftershave when alcohol is not available), and one incident of property damage. Many of his charges (well over 20) have not been prosecuted or Jerry is released with only a fine to pay, because Jerry will often use his mental retardation to pretend he doesn't understand the police or the judge.

E. Substance Abuse Treatment - Outpatient - Jerry has had outpatient counseling off and on for the past 4 years, his sobriety is sporadic. Residential treatment - Jerry has two previous admissions to residential treatment. The information there was at a level which was too high for him, yet he maintained sobriety for six months following treatment. Shelter - He has had numerous admittances, also a Halfway House and group home for alcoholics.

One thing that has been an outstanding problem with Jerry is his manipulative behavior. He knows systems and he knows how to use them - BMR, alcoholism rehabilitation programs, SSI, hospitals and the courts.

III. CASE PLANNING

A. Joint Planning - The Mental Retardation Alcoholism Project became involved with Jerry's case in August of 1982. At that time, Jerry was moving back and forth from Aroostook County to Bangor. A team meeting was called to discuss his case. BMR staff from Aroostook County and Bangor, the Project Coordinator, and Jerry met to plan for his treatment. (Representatives from local substance abuse treatment providers were unable to attend but were informed of the team's decisions). These meetings have provided an opportunity for the team to discuss case management. It also

gave Jerry a chance to get consistent messages from all care providers. Although he has continued at times to try to play one person against another, these manipulation attempts were unsuccessful.

- B. Locate a Supportive Environment** - Jerry was an individual who clearly wanted independence. At the same time, it was just as clear to providers that, in order to maintain sobriety, Jerry would need a supportive and somewhat structured environment. The team decided that a Group Home for alcoholics would offer him that support (access to AA meetings, his own room, shared transportation and non-mentally retarded peers). Jerry agreed to this plan but stated that he would like to live on his own when things got better. A plan was set up to assist Jerry in getting an apartment if he was able to maintain sobriety on his own for one year.
- C. Integration into AA** - There were two ways that Jerry could become familiar with AA. He attended meetings at the Shelter (the staff were very willing to help Jerry become used to the meetings). He also had the support and encouragement to go to meetings at the Group Home.
- D. Set up a Reward System** - BMR, as representative payee for Jerry, knew that money was very important to him. It became clear to the team that, although Jerry had maintained sobriety for awhile, an incentive program was necessary to help him stay that way. Jerry agreed to a plan that would give him extra spending money if he attended his AA and treatment regularly.
- E. Group Therapy** - Jerry was used to dealing with people on the streets and could communicate verbally quite well. Therefore, his participation in group therapy was fairly good. This was supplemented by Shelter staff who worked with him individually to deal with the scapegoating by others and to understand the information which was at a level too difficult for him.
- F. Involve in a Meaningful Task** - The team recognized the need for Jerry to become involved in a meaningful task but had difficulty in locating something that was appropriate for his needs. He was too high functioning for sheltered workshops for the mentally retarded and lower skill jobs were very difficult to come by. Jerry, however, solved this problem on his own and became a volunteer at the Halfway House.

Things went relatively smooth for Jerry and he was able to maintain sobriety for nearly eight months. At that time, he began playing his old games and soon after began drinking. The team continued to meet and plan for his case. (Jerry stopped coming to the meetings). The team decided that an assessment of his "enabling" systems was necessary. The following plan was set up:

- A. Contract** - BMR set up a contract with the client. He would be dealt with in their office only if he came in sober. This included the times when he would come in for his SSI check. Jerry agreed.
- B. Work with the Courts** - Jerry again was being arrested and then given a fine for his actions. This meant very little to him since BMR was his rep. payee and, therefore, budgeted his money and helped pay his bills. Since substance abuse treatment providers often dealt with the courts, the shelter agreed to make recommendations to them, including the need for treatment, the next time he got caught.
- C. SSI** - Jerry abuses this system just as he does many others. When Jerry began drinking, his money went for booze, not a place to live or food. Social Security has a rule that, in order to receive benefits, the individual must have a permanent residence. Jerry, who usually lives "on the streets" when he's drinking, was told that SSI would be contacted if he did not have a room.
- D. The Double-bind** - One problem that we have not been able to solve is a double bind in the System and how Jerry is very wise to this fact. BMR must manage his case to assure that he has money for food and shelter. Jerry knows where he can get free shelter and free food, so his money can be spent on booze. He knows that he will always be taken care of.

We have continued to work with Jerry's case, within our limits. He made considerable progress during his seven and a half months of sobriety, and we have continued to confront his drinking and drinking behavior in hopes that he will again try chemically free living.

Sally is a 32 year old divorced woman with a below-average intellect.

I. HISTORY

- A. Substance Abuse** - Sally has had numerous problems with her

drinking. It has affected her physically, emotionally, legally, vocationally and vocationally. She has been in and out of treatment programs for the past 8 years. She hangs out with a group of "street people" who have on many occasions, taken advantage of her physically and financially. She has been diagnosed as being in the middle to late stages of alcoholism.

- B. **Emotional** - Her emotional background has been very unstable. She has been on tranquilizers and sleeping pills for the past three or four years. She lapses into deep depressions, particularly after being physically abused and has past attempts at suicide. She has received mental health services both on an outpatient basis and institutionally.
- C. **Medical** - Sally has been hospitalized many times primarily for detoxification, broken bones and bruises from being abused and other accidents while drinking.
- D. **Arrests** - Most of her past arrests are alcohol related and include shoplifting, unlawfull trespass and drunk and disorderly.
- E. **Family** - Sally has no family ties at this time. Her family has been unwilling to support her past attempts at sobriety and have refused to have any contact with her. Sally often talks about her family and would like very much to re-establish relationships with them.
- F. **Deficits of Intellectual Functioning** - Sally attended public schools and has completed the eighth grade. She reads at about the third or fourth grade level. Sally has the need for others to problem solve for her and uses inappropriate behavior to get her needs met. Sally is acutely aware that she is considered "not as smart as other people," which contributes to her low self-esteem.

Sally entered the substance abuse treatment system through a recommendation from her Probation Officer.

II. CASE PLANNING

- A. **Joint Planning** - The substance abuse counselor called a meeting of all the providers who have worked with Sally in the past year. They included her social worker from the mental health system, her Probation Officer and the counselor. A representative from BMR was invited to provide consultation as was the Coordinator of the

Mental Retardation Alcoholism Project. After a period of sobriety, Vocational Rehabilitation was also asked to join the team. Sally was always included in the case planning meetings which were held intermittently throughout her treatment. The counselor assumed case management.

- B. Locate a Supportive Living Environment** - The team felt that Sally should try to remain sober in an outpatient treatment program because of her poor history in residential treatment, her desire to be taken care of and waited upon (this is how she views hospitals based upon past admissions), and because the team wanted to complete a more thorough assessment. The next step was to encourage her to find a more supportive environment or for her to at least find a new apartment that was away from the street population.
- C. Reassess Her Mental Health Status** - It was unclear to the case planning team whether her history of depression and suicide was a physical concern or a result of her progressive use of alcohol and drugs and her poor socialization. The team recommended a Mental Health Status Exam and a review of her medication.
- D. Substance Abuse Counseling and Education** - Sally agreed to attend outpatient counseling three times per week (for 20 minutes each session). The counselor will use materials which provide concrete information about alcohol and drug abuse and which provides general basic skills for living chemically free. Since Sally says that she "likes the movies," the counselor will try to expose her to as many films as possible about substance abuse and will spend time discussing them.
- E. Involve in a Meaningful Task** - The team sees this as a key factor in Sally's self-esteem and therefore her ability to maintain a quality sobriety. They agreed that after she has become accustomed to her participation in counseling and AA, they will work together to locate an activity which will have meaning to Sally. They agreed that this may be done through Vocational Rehabilitation or a Volunteer Agency.

At this time, Sally has refused to attend AA. Perhaps with a little more help in becoming comfortable with the program, she would have felt more compelled to attend. Nevertheless, with the exception of one slip, Sally has over one year of sobriety. She attends the counseling sessions regularly and uses her health and social services appropriately. She has

learned to ask for help when she feels down or when she thinks people are taking advantage of her. She lives in her own apartment (shared with another woman) and does babysitting for the time being. She states that she would like "a real job."

APPENDIX A
FOR THE SYSTEM

SERVICE AGREEMENT

Agreement made on this first day of March 1983 between _____ (hereinafter referred to as Substance Abuse Treatment Program or SATP) and _____ (hereinafter referred to as Agency) for purposes of improving the ability of SATPs to provide substance abuse treatment services to the mentally retarded substance abuser; also coordinating and monitoring substance abuse treatment services to the mentally retarded individual.

A. Services provided by SATP - The SATP shall:

1. Provide contracted substance abuse services to individuals who are clients of the Bureau of Mental Retardation or to individuals who have limited intellectual functioning and have been approved by the Bureau of Mental Retardation for inclusion in the Project's pilot effort.
2. Assess the client's needs for substance abuse treatment and develop a plan for the delivery of appropriate services. This plan will be approved by the Agency and the Bureau of Mental Retardation Regional Office.
3. Provide outpatient individual or group counseling in a manner consistent with the approved plan.
4. Provide a monthly report to the Agency and the Bureau of Mental Retardation reflecting the client services provided.
5. Participate in staff training provided by the Agency.

B. Services provided by the Agency - The Agency shall:

1. Reimburse the SATP for substance abuse services identified in this Agreement after all other resources have been applied.
 - a. Rate of \$25 per hour for outpatient assessment services.
 - b. Rate of \$25 per hour for outpatient individual counseling services.
 - c. Rate of \$6 per hour for outpatient group counseling services.

- d. Rate of \$15 per hour for participation in joint planning meetings with mental retardation service provider and other service providers.
2. Provide the SATP with any reports concerning the SATP, that the Agency submits to its grant funding source.
3. Provide staff training to SATP and mental retardation service providers.
4. Make referrals to SATPs when they have come to the attention of the Project Coordinator.
5. Provide consultation to SATPs regarding specialized treatment methods.

E. Confidentiality

1. Clients seen at the SATP will be asked to approve the release of information to the Agency and the Bureau of Mental Retardation.
2. Agency and SATP agree to maintain the confidentiality of all substance abuse patient information in accordance with Federal Regulations on confidentiality of alcohol and drug abuse records (42 CFR Part 2) and the Rights of Mentally Retarded Persons (Chapter 186-A, Section 2143.3 and section 2143.14)

F. Termination of Agreement

This Agreement will be terminated on August 31, 1983 or upon thirty (30) days written notice by either party. Bills for services which occurred before August 31, 1983 will be accepted until September 15, 1983. Modifications may be executed at any time provided they are submitted in writing and mutually agreed upon by both parties.

FOR

FOR

Dated:

Dated:

PROCEDURES FOR THE PROVISION OF SERVICES FOR THE MENTALLY RETARDED SUBSTANCE ABUSER

A. Clients of the Bureau of Mental Retardation (BMR)

1. BMR clients will generally enter the substance abuse treatment system by contacting the regional BMR office.
2. A representative from the BMR regional office and the client will contact the contract substance abuse treatment program for an evaluation. The Client Services Coordinator (CSC) will participate in the assessment process. In the event that the client has entered the substance abuse treatment system through other means (human service program, self, medical, law enforcement, etc.) and it has been determined that the individual is a client of BMR, the substance abuse treatment program representative will contact the regional BMR office.
3. A treatment plan will be written by the substance abuse counselor, the client and the CSC.
4. The plan will be reviewed by the BMR regional supervisor and the Project Coordinator to assure that it is consistent with recommendations made at the regional forums. Upon review and approval of the treatment plan the Project Coordinator will initiate the reimbursement process.
5. The Project Coordinator and the BMR regional supervisor will review all monthly reports relating to the clients progress.

B. NON-BMR CLIENTS

1. Clients will enter the substance abuse treatment system through the traditional referral systems (social service, medical, law enforcement, self, etc.)
2. Following an assessment, the substance abuse treatment program representative will contact the BMR regional supervisor with information which might indicate that this client should be included in the Project's efforts. The BMR regional supervisor and a representative from the BMR central office will decide whether or not the individual should be included in the Project efforts.

3. When the client has been approved and a treatment plan has been submitted to the Project Coordinator and the BMR regional supervisor, the reimbursement process will be initiated.

C. All clients will be asked to sign a release of information form. In the event that someone chooses not to sign a form the following procedures will occur:

1. The Project will reimburse for BMR clients after all other resources have been exhausted. These individuals will not be included in the monitoring and data collection portion of the Project.
2. The Project will not reimburse for non-BMR clients who choose not to sign a release of information.

Cooperative Service Agreement

This Agreement is entered into between (BMR), and _____, hereinafter referred to as the treatment program, for the purpose of providing alcoholism treatment services to mentally retarded persons from Referring Agency's service area.

A. Services provided by the Referring Agency. The Referring Agency shall:

1. Provide information for its staff about the Referring Agency's services.
2. Make referrals to the treatment program of clients who require an assessment for substance abuse.
3. Provide the treatment program with a history and assessment of the client's problems and resources at the time of the referral.
4. Assist the treatment program in securing the cooperation and participation of appropriate concerned persons for referred clients.
5. Work with the treatment program in providing an orientation to the substance abuse program for appropriate clients.
6. Inform the treatment program of joint planning meetings convened by BMR.
7. Work with the treatment program to arrange a specific Aftercare plan for each client from the Referring Agency's Service area, who has completed the treatment program.
8. Arrange transportation, as needed, to and from the intake screening.

B. Services provided by the treatment program. The treatment program shall:

1. Provide information for the Referring Agency about the treatment program services.
2. Provide alcoholism and drug abuse treatment for appropriate clients by the Referring Agency. If the client is not appropriate but

in need of substance abuse counseling, the treatment program will work with the Referring Agency in making a referral to the appropriate resource. The treatment program will also provide a reason in writing if the client is refused admission.

3. Schedule screening for referred client to include participation by the mental retardation service representative.
4. Involve the Referring Agency in the Aftercare planning process.
5. Inform each client, prior to completion of treatment, of his or her specific assignment to an aftercare program.
6. Notify the Referring Agency upon the discharge of each client and forward a written discharge summary.

C. Termination of Agreement:

This Agreement shall be reviewed at least annually by the representatives of each party. The Agreement may be terminated upon thirty days written notice by either party. Modifications may be made at any time provided they are put in writing and mutually agreed upon by both parties.

For

For Referring Agency

Name

Name

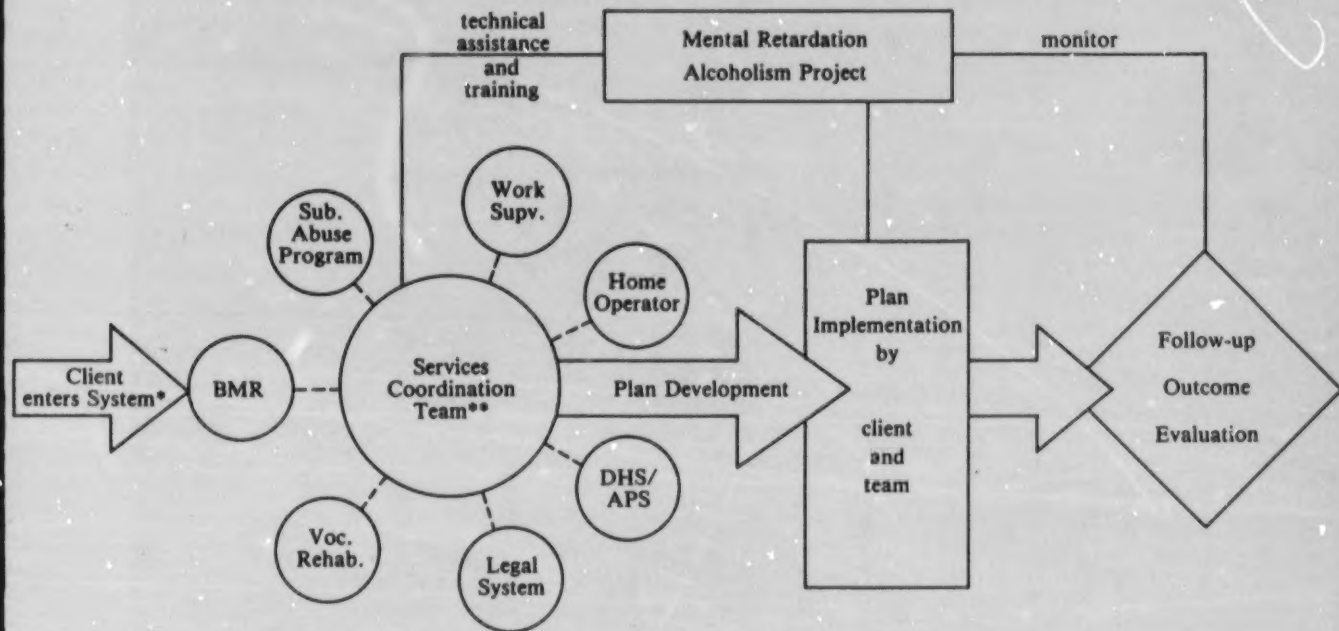
Position

Position

Date

Date

**Relationship of the Mental Retardation Alcoholism Project to Case Planning
and the Treatment Process for the Intellectually Limited Substance Abuser**



* Client may enter the system through the BMR caseload or the community at large

** Primary responsibility for leading the team (Case Manager) varies depending on the status of the client with BMR, Adult Protective Services and other programs

TRAINING OUTLINE

PHASE 1:

The first phase of training is designed to give both substance abuse and mental retardation service providers an understanding of the other disability. Whenever possible, using trainers from the same service area will help to establish relationships among programs.

I. To Mental Retardation Service Providers

A. Identification and Referral of Substance Abuse

1. Understand the psychology and physiology of substance abuse.
2. Have some basic diagnostic criteria for identifying substance abuse.
3. Be familiar with the different types of treatment and referral sources.

B. Intervention with a Streetwise Population

1. Assess the psychological motivators
2. Know the elements of an intervention process
3. Develop a plan for confronting the substance abuser
4. Practice an intervention for the client with fewer resources

C. Treatment and Recovery: Role of Support Service Providers

1. Know the primary methods of substance abuse treatment
2. Assess your own attitudes about substance abuse
3. Understand the importance of concerned person involvement in treatment and the recovery process
4. Recognize the limitations of substance abuse treatment

II. To Substance Abuse Treatment Providers

A. Overview of Mental Retardation

1. Be familiar with the different types of services for the mentally retarded population
2. Distinguish between myths and facts of mental retardation
3. Understand the rights of the mentally retarded person

B. Strategies for Working with the Mentally Retarded Person

1. Understand the process of learning
2. Be familiar with historical approaches to treating the mentally retarded client
3. Understand methods of goal selection
4. Understand methods of teaching the mentally retarded person

PHASE 2

The second phase of training begins to explore some of the special problems and alternatives for treating the mentally retarded substance abuser and should be targeted primarily for the substance abuse treatment provider. However, mental retardation service providers may also benefit from these programs.

I. The Poly-Substance Abuse in the Alcoholic

A. Street Drugs

1. Scope of the problem
2. Discussion of groupings of drugs
3. Treatment plan development for poly-substance abuse patients

B. Prescription Drug Abuse

1. The problem

2. The prescribing professional
3. Diagnosis and treatment plan development
4. Managing the patient in treatment

II. Assessment Interviewing for treatment Planning

A. Assessment

1. Readiness: Assessing the client's reasons for being in treatment
2. Relationships: Assessing the client's relations with family and peers
3. Rationality: Gross assessments of psychopathology, suicidal potential and potential for violence
4. Resources: Assess the clients' resources on which treatment can build

B. Treatment Planning

1. Involving the family and ancillary services providers
2. Documenting needs and resources
3. Developing action statements to address these needs
4. Tailoring the plan to meet the client's capabilities

III. Reality Therapy and Behavior Modification: Theories and Practical Application

A. Reality Therapy

1. How reality therapy developed
2. Four basic needs
3. Success and failure identities
4. Behavior, the control of perception psychology

B. Behavior Modification

1. History of behavior modification
2. Principles and assumptions
3. Increasing behavior

C. Compare and Contrast the Two Theories

1. Initiating new behavior
2. Decreasing undesirable behavior

Some Additional Training Topics:

- I. Building Client Self-Esteem: Issues for Rehabilitation Specialists
- II. Management of Psychotropic Medications with the Mentally Retarded Substance Abuser
- III. The Manipulative Client in Treatment
- IV. Experiential Training on Treating the Mentally Retarded Substance Abuser
- V. Intervention, Procedures with the "Street People"
- VI. Prevention Strategies for the Mentally Retarded Substance Abuser

APPENDIX B
FOR THE ASSESSMENT PROCESS

This Interviewing Form consists of three parts:

- I. Chemical Dependency Assessment**
- II. Personal Needs Assessment**
- III. Caseworker's Assessment**

The first section - Chemical Dependency Assessment - is a sample of the general information gathered by most substance abuse treatment providers in Maine. It includes questions relating to chemical use, medical background, family and peer relationships, education, work and legal histories.

The second section - Personal Needs Assessment - ask questions relating to the individual's likes and dislikes, feelings and problem solving mechanisms. This information is also gathered by treatment specialists. However, the client is usually given the responsibility in treatment for discussing these issues and feelings. Treatment plans are then reshaped to include a way of dealing with them. For the intellectually limited client, it may be more useful to gather this information early in the assessment process and not to depend upon the client's initiative to offer this information. This section is designed to give case planners more information at an earlier time about the client's motivations and treatment needs.

The third section - Caseworker's Assessment - is a questionnaire which can be given to the client's BMR or APS caseworker. It is also designed to give the case planners more information for treatment development.

These three forms can be used together as a complete assessment tool or parts two and three can become a part of the assessment form that you are currently using.

PART I

**INTERVIEWING FORM
CHEMICAL DEPENDENCY ASSESSMENT**

CLIENT _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____

INTAKE COUNSELOR _____ DATE _____

BMR Client: Yes _____ No _____ Other _____
(please specify)

Client Services Coordinator (CSC) _____ Phone _____

Other Concerned Persons at Intake (name and relationship)

***** Chemical Use History *****

When was last drink or drug? _____

Reason for being here? _____

Are you concerned about your drinking/drugging? _____

How long have you had a problem with alcohol or drugs? _____

Explain your alcohol and drug use (what kinds, how much and how often)? _____

How do you act when you're drinking/drugging? _____

How does it make you feel? _____

Do you drink when you're angry _____ sad _____ happy _____ lonely _____
friendly _____?

Do you get angry when people talk to you about your drinking/
drugging? _____

Do you ever drink more than you wanted to? _____

or get drunk when you didn't want to? _____

Have you ever had treatment for alcohol or drug use (Be specific)? _____

***** Medical History *****

History of DTs, shakes, blackouts? _____

Seizure disorder? _____

Allergies? _____

Medications (if so, list kinds) _____

Illnesses? _____

Physical problems? _____

Somatic concerns? _____

Date of last physical? _____

Are medical records available _____?

Name of Physician _____

History of Mental Illness? (specify diagnosis) _____

If yes, is it medically controlled? _____

Date of last psychological evaluation _____

Is it available? _____

Name of psychologist _____

***** Family *****

Guardian _____

Mother _____

Father _____

Siblings _____

Does anyone else in your family have a drinking/drugging problem? _____

Do you live alone or with someone else? (list) _____

Name of residence, if any _____

What is your relationship with your family? _____

***** Other CPs *****

List any other close friends of the client _____

Is the client receiving any other health or social services? _____

***** Education and Work History *****

Highest Grade Completed is: _____

Read _____ Write _____ at what level _____

Do you work? (if so, where) _____

Where was your last job? _____

What do you do best at work? _____

Have you ever been fired or refused a job because of your drinking or
drugging? _____

***** Legal History *****

Have you ever been arrested? _____

If yes, please describe _____

Are you currently on probation? _____

If so, name of P.O. _____

PART 2

INTERVIEWING FORM Personal Needs Assessment

Name _____

CSC _____

How do you feel right now? _____

Lately, do you usually feel angry? _____ sad? _____ mad? _____ happy? _____

Scared? _____ Lonely? _____ Don't know _____

What do you like to do best? _____

What makes you happy? _____

What are some other things you enjoy doing? _____

Do you go to church? _____ AA _____ Other clubs or groups _____

What would you like to do in the future? _____

Who do you like to spend your with with? _____

How do you feel when people say you're different from them? _____

Who do you go to if you have problems? _____

What do you do if you get angry? _____

Sad? _____

Additional Observations: _____

PART 3

QUESTIONNAIRE (CSCs) CASEWORKER'S ASSESSMENT

What led up to the client's coming here?

Do you think your client has a problem with alcohol or other drugs?

What are your expectations?

What do you think the client's motivation and expectations for being here are?

What do you see as the client's coping skills?

What things are important to your client?

Who does your client trust?

How does your client deal with authority?

Describe your client's living situation?

Do you know of specific motivators for your client?

What are your recommendations for this client?

Are you willing to participate in the treatment process?

The Caseworkers Questionnaire on the following page is similar to a "Concerned Person" Questionnaire that many of the substance abuse programs are currently using. One difference, however, is the focus on the caseworker's impressions of the client instead of their own personal feelings. This questionnaire can be used as a tool in a chemical dependency assessment or as an outreach or training tool to promote a discussion about chemical dependency among people with intellectual deficits.

Remember that when you are presenting this questionnaire to a caseworker, you must explain its implications. Individually, these questions do not necessarily indicate a substance abuse problem. In fact, some questions (such as #7 and 11) may indicate some other kind of problem. Collectively, however, they can become a useful tool for identifying individuals with a substance abuse problem.

CASEWORKER QUESTIONNAIRE

Please fill out this questionnaire for your clients who drink alcohol or take drugs.

	Yes	No
1. Do you worry about your client's drinking or chemical use?	_____	_____
2. Do you spend more than the average amount of time managing client's case?	_____	_____
3. Have you ever had to assist the client in locating new housing because of his or her drinking behavior? How many times in the past 2 years? _____	_____	_____
4. Does your client function at a level which is lower than you expect he or she is capable of?	_____	_____
5. Does your client have a history of poor memory retention? If not, has this recently become a problem for your client?	_____	_____
6. Has your client experienced any kinds of problems while or shortly after he or she has been drinking or drugging?	_____	_____
7. Does your client experience mood swings?	_____	_____
8. Is your client defensive about his or her drinking or drugging? Does your client brag about his or her substance abuse?	_____	_____
9. Do you try to control your client's drinking or drugging?	_____	_____
10. Are other people (such as family members) concerned about your client's substance usage?	_____	_____
11. Does your client have trouble getting along with others?	_____	_____
12. Has your client ever been fired or refused work as a result of his or her drinking? or behavior?	_____	_____
13. Are you afraid of physical or verbal abuse when your client is drinking or using chemicals?	_____	_____
14. Does your client spend money that is budgeted for food, clothing, or housing on alcohol or drugs? (If you are the client's representative payee, is he or she often coming to you for extra money?)	_____	_____
15. Is client on prescribed medication? If so, does your client abuse or misuse these drugs?	_____	_____
16. Does your client stop taking his or her medications when drinking?	_____	_____

If you answered "yes" to two or more of these questions, there is a strong possibility that your client has a substance abuse problem. Early intervention will increase the chances of a successful recovery. Please encourage your client to get a substance abuse evaluation to determine the extent of the problem.

You may contact the Mental Retardation Alcoholism Project or a local alcoholism treatment program so that you and your client can find out more about chemical dependency.

QUESTIONS TO ASK THE PSYCHOLOGIST

1. What is the best and least restrictive environment in which the client can learn?
2. Is this client able to generalize information from a residential or outpatient treatment program to his or her life in the community?
3. How does this client deal with authority?
4. To what are this client's behavioral problems attributed?
5. How well does this client interact with peers of average or better than average intellect?
6. Describe the level of insight this client exhibits into himself or herself?
7. What serves as reinforcers/motivators for this client?
8. Is this client learning disabled or is he or she mentally retarded?
9. Does this client learn more through pictorial representations or verbal exchange?
10. What do you see as primary issues for this client? Can they be addressed independently or does this client need to have all of his or her issues addressed concurrently?
11. Do you feel that this client's drug use is situational, self-medicating, or dependent?

These are some examples of questions you can ask the psychologist to obtain specific information from an evaluation.

DIFFERENCES BETWEEN MENTAL RETARDATION AND MENTAL ILLNESS

Many people make the common mistake of confusing the mentally retarded person and the mentally ill person. However, it is most important to understand that these disorders are separate and distinct conditions. The following chart compares the differences between the two.

MENTAL RETARDATION differs from MENTAL ILLNESS

- | | |
|---|---|
| <p>A. Retardation refers to sub-average intellectual functioning.</p> | <p>A. Mental illness has nothing to do with IQ. A person who is mentally ill may be a genius or may be subaverage.</p> |
| <p>B. Retardation refers to impairment in social adaptation.</p> | <p>B. A mentally ill person may be very competent, socially but may have a character disorder or other aberration.</p> |
| <p>C. Retardation usually occurs during the period of development or is present at birth. However, a brain injury or toxemia may cause retardation in anyone at any age.</p> | <p>C. Mental illness may strike at any time.</p> |
| <p>D. In mental retardation, the intellectual impairment is permanent but can be compensated through development of the person's potential.</p> | <p>D. Mental illness is often temporary and in most cases is reversible. It is not a developmental disability.</p> |
| <p>E. A retarded person can usually be expected to behave rationally at his operational level.</p> | <p>E. A mentally ill person may vacillate between normal and irrational behavior.</p> |
| <p>F. A retarded person will not be violent except in those situations that cause violence in non-retarded persons.</p> | <p>F. A mentally ill person may be erratic or even violent.</p> |
| <p>G. A mentally retarded person has a learning disability and uses the skills of educators, psychologists, and vocational rehabilitation technicians.</p> | <p>G. A mentally ill person utilizes the services of psychiatrists, psychotherapists, or psychologists.</p> |

Georgia Association for Retarded Citizens, **Police Education Manual**, P.6

Possible Indicators of Deficits in Intellectual Functioning

Mental Retardation is defined as "a condition of significantly subaverage intellectual functioning manifested during a person's developmental period existing concurrently with demonstrated deficits in adaptive behavior." Thus, mentally retarded people must have a full scale I.Q. of 70 or below. The retardation must have its onset prior to age twenty-two and impaired adaptive behavior may be reflected in maturational rate, learning ability or social adjustment

Level of Functioning	Actual Age	Mental Age	IQ Range
Profound	21	0-3 years	Below 20
Severe	21	2½-7 years	20-40
Moderate	21	7-11 years	40-55
Mild	21	11-14 years	55-70

There are other individuals in Maine, however, who have significant deficits of intellectual functioning (IQ between 70-85) but are not legally "mentally retarded." Many of these individuals experience similar problems as those who are mentally retarded. Below are some possible indicators of decreased intellectual and social functioning. **IN NO WAY ARE THESE INDICATORS ABSOLUTE!** If you have a client who demonstrates some of these characteristics, you should contact the Mental Retardation Alcoholism Project or the Regional Office of the Bureau of Mental Retardation.

Physical

1. Is the individual appropriately dressed for the season?
2. Does the individual have any notable physical characteristics such as Down's Syndrome?
3. Does the client have problems with motor coordination? Does he or she walk with a gait?
4. Does the client have a slow reaction time? (For example, between asking and answering questions?)

Speech

1. Does the client have any speech impairments?
2. Does the client parrot or tell you what they think you want to hear?

Mental

1. Does the client understand abstracts such as proverbs?

2. Is the client oriented to time, place and date?
3. Does the client have a recent or rote memory?
4. Can the client generalize information?
5. Does the individual have a short attention span?
6. Can the client read and write?
7. Does he or she count money or coins?

Social

1. Does the individual prefer the company of younger peers?
2. Does the person have an excessive over-desire to please?
3. Does the client act appropriately for his or her age?

APPENDIX C
FOR TREATMENT
AND AFTERCARE

"Express and informed consent" means consent voluntarily given with significant knowledge and comprehension of the subject matter involved so as to enable the person giving consent to make an understanding and enlightened decision, without any element of force, fraud, deceit, duress or other form of constraint or coercion.

In other words, the client should be given adequate information about treatment so that he or she can choose whether or not to participate. You are encouraged to use the assistance of the client's Client Service Coordinator (CSC) in explaining your program to the client.

On the following page is a sample form taken from "Guidelines for the Use of Behavioral Procedures in Maine Programs for Retarded Citizens."

INFORMED CONSENT:

1. a. As legal guardian for this client, I, _____
Name of Legal Guardian
hereby consent to the use of treatment procedures described on the
previous pages in the treatment of _____
Name of Client

OR

- B. (for competent client), I, _____, hereby
Name of Client
consent to the use of the treatment procedures described on the
previous pages for me.

2. I acknowledge that no guarantees have been made to me regarding the results of this treatment.
3. I understand that within the scope of this treatment there is no intent to cause detrimental side effects to the client.
4. I also understand that the treatment procedure described above will be closely monitored and supervised and in the event of the observation of any detrimental side effects which might be injurious to the client, the treatment procedures will be immediately terminated. I further understand that the decision to terminate may be made either by myself or by the therapist. However, normally the decision will be made jointly.
5. This form has been fully explained to me and I certify that I understand its contents.

Signature of person legally authorized to consent for client:

Address _____
City & State _____
Relationship _____

Date

Witness:
Signature _____
Address _____
City & State _____

CASE MANAGEMENT

Case Management involves reviewing periodically the services which a client is receiving to insure that they are meeting his or her needs. It is best done by assigning responsibility for that review to a single member of the care team. Since BMR Client Service Coordinators (CSCs) already have that responsibility, any BMR client's Case Manager should be his or her CSC. If the individual is not a BMR client, then another member of the team could be given that responsibility (for example, the primary substance abuse counselor, adult protective worker, probation officer, etc.).

The Case Manager gathers information necessary to monitor the patient's adherence to treatment or aftercare plans. If the patient drops out of aftercare or treatment, the Case Manager contacts the patient and attempts to reconstitute the plan. Periodically, even if there are no breakdowns in the execution of an aftercare or treatment plan, the Case Manager may sit down with the patient to insure that the patient's goals are being met. The Case Manager is someone who knows the patient and is known by the patient. The patient knows that the Case Manager has a responsibility of following up on breakdowns in the care plans. The patient also knows that the Case Manager may be of assistance in obtaining needed services.

An additional responsibility of the Case Manager is to convene joint planning meetings involving the various providers who are serving the client. These meetings offer providers an opportunity to be consistent in their planning efforts and to coordinate different aspects of the planning process.

**GUIDELINES FOR THE USE
OF BEHAVIORAL PROCEDURES
IN MAINE PROGRAMS FOR
RETARDED CITIZENS**

Section I Introduction

A) PURPOSE AND SCOPE

The following document has been written to establish guidelines for the use of behavioral procedures in facilities, programs and services for mentally retarded persons in the State of Maine, which carefully:

- 1) outline the process by which good quality behavioral programming is designed and implemented;
- 2) categorize the most common behavioral procedures by function, and further categorize procedures to weaken behavior by degree of aversiveness;
- 3) describe the qualifications and functions of the various personnel designing and implementing behavioral programs;
- 4) describe the steps necessary for review and approval of different types of behavioral programs, especially treatment programs which involve the use of aversive procedures.

We are concerned in these guidelines with the theory and practice of behavior modification. The guidelines are not intended to address or regulate other therapeutic approaches. Although guidelines for these other approaches may in fact be appropriate and necessary, they are outside the scope of this effort.

We define **behavior modification** as a theory and practice with the following characteristics:

- 1) based on experimental and social psychology;
- 2) emphasizes the importance of the environment in determining human behavior,
- 3) posits that behavior can be acquired, strengthened or weakened by observation coupled with systematic arrangement of events in the environment in which behavior occurs.

Behavioral procedures are specific techniques which are derived

from the findings of behavioral research, empirically verified, and then used to modify behavior in a planned way.

The guidelines are concerned with the employment of behavior modification in facilities, programs and services used by mentally retarded persons in the State of Maine. The Task Force was authorized by the director of the Maine Bureau of Mental Retardation (BMR) with the intention that the completed guidelines would become part of BMR policy and obligatory for agencies fiscally monitored by BMR. Therefore, the guidelines reflect current Maine law and relevant State and federal regulations. Where the Task Force has found inconsistencies and problems with existing laws, regulations or policies, these will be sent to the BMR director in a separate letter with recommendations to foster quality behavioral practice.

Behavioral procedures, when intelligently used, provide powerful tools for the habilitation of mentally retarded persons and also for the treatment of retarded persons with serious behavior problems. These guidelines clearly describe the way in which behavioral procedures can be effectively and humanely used for both educational and therapeutic purposes. The Task Force hopes that these guidelines will be disseminated and widely read by service providers, families and friends of retarded individuals, service monitors and advocates, and administrators so that good quality behavioral practice becomes increasingly used throughout the State mental retardation system.

B) PHILOSOPHICAL BASIS

The Task Force which developed these guidelines for the use of behavioral procedures, used as its foundation the laws and decrees which are basic to the provision of services to mentally retarded individuals in the State of Maine. These are:

- 1) Bill of Rights for Mentally Retarded (34 MRSA 186-A)
- 2) Services for the Mentally Retarded (34 MRSA 221, 223, 225, 229)
- 3) Pineland Class Action Consent Decree (Wuori vs. Zitnay #75-80-5D)

These documents and these guidelines are based upon the following values:

- 1) Each individual is a valued member of society and is guaranteed the constitutional rights of life, liberty and the pursuit of happiness.
- 2) In order to develop to their highest potential, individuals must be provided with opportunities which a) increase the range of their adaptive behavior, b) strengthen a sense of personal and social worth and, c) foster their ability to positively cope with the environment.
- 3) Recognizing that the environment plays a large role in determining human behavior, the Task Force believes that behavioral procedures can be a way to modify or influence behavior in order to enhance an individual's positive growth and development.
- 4) The application of behavioral procedures should occur in accordance with the following principles:
 - a) Normalization: "Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible." (Wolfensberger, 1972).
 - b) Dignity of Risk: allowing the individual the human dignity of risk; the experiencing of risk-taking of ordinary life which is necessary for normal human growth and development.
 - c) Self-Determination: providing individuals the right to make choices and assert their wishes, desires and aspirations regarding their own lives.
 - d) Individualization: recognition and fostering of uniqueness in every person within broad limits of social acceptability.
 - e) Developmental Model: use of procedures to optimize a normal sequence of development.
 - f) Least Restrictive Alternative: the least drastic procedures available should be used in achieving desired goals. This principle is described throughout the guidelines by the concept of hierarchy of treatment.

C) DESIGN AND IMPLEMENTATION OF BEHAVIORAL PROGRAMS

1) Basic Needs and Basic Rights

There are several factors to consider before beginning behavioral programming with a client. Mentally retarded persons have the same basic needs as other persons; for food, clothing, housing, health care, for social contact, for stimulation, for comfort and security for challenges. The State of Maine guarantees mentally retarded persons in Public Law 34 MRSA 186-A a system of care to meet their needs and also articulates their same basic rights as other citizens to individual dignity, liberty and the pursuit of happiness. This system of care should operate under the principles of normalization, implying the mentally retarded person should have the least restrictive setting possible and receive the habilitation, educational or vocational training which will foster independent and productive living. Other more specific rights including the right to a personal living space and privacy, reasonable use and control over personal possessions, private communication, physical exercise, social activity, and fair compensation for their labor.

Behavior Programming and especially programming to reduce maladaptive behavior **should never be seen as a substitute for meeting client's basic needs or for full protection of client rights.** Where serious deficiencies in appropriate care or violations of rights exist, it is the responsibility of the service provider and BMR to correct the problem. When this is done, behavior programming can provide a powerful support in habilitation and therapy.

2) Habilitation: Shaping Adaptive Behavior

A primary mission of BMR and all service providers is **habilitation**, which is assisting an individual to acquire and maintain life skills which enable him to a) competently cope with his environment, b) live more independently, and c) have a sense of personal and social worth. The Task Force believes that habilitation is best accomplished through a planning process like BMR's Individual Prescriptive Program (IPP) system. The process should a) involve the client, his/her representative and key members of his/her support system, b) include accurate information about the client's history, physical and mental health, and current performance, c) set goals to address the most important needs, d) develop a plan with general methods

to achieve goals, and e) assign individuals to carry out aspects of the plan. Detailed IPP procedures are delineated in BMR's IPP manual and will not be duplicated here.

Once habilitation goals have been determined, a behavioral approach is often the most effective means of teaching the new skills. A behavioral approach consists of the following steps:

- a) assessment of current behavior in a designated skill area;
- b) specification of a target behavior in objective, measurable terms. This may be stated as long-term goals (yearly) broken into short-term objectives (monthly or weekly);
- c) selection of reinforcers based on client's known preferences;
- d) writing out the step-by-step procedure for carrying out the program by specifying the exact behaviors required of the client and actions of the staff;
- e) collection of data to analyze the effectiveness of the program and modify accordingly.

The Definitions section lists the specific procedures used to teach adaptive behavior (IIA) and those used to strengthen or reinforce adaptive behavior (IIB).

3) Reducing Maladaptive Behavior

Normal development involves not only the acquisition of adaptive behavior, but also the elimination of maladaptive behavior. Maladaptive behavior can arise at any point in the developmental process. When an individual's basic needs are not met, he or she may engage in a variety of behaviors in an attempt to meet them, some of which may be atypical or exaggerations of normal behavior. When inappropriate behavior leads to satisfaction of one's needs, those behaviors will be employed again. If an individual achieves his/her goals through a variety of inappropriate behaviors, he/she will develop a repertoire of maladaptive behaviors. Similarly, when an individual is consistently denied opportunities to meet basic needs, he/she becomes frustrated and may react with anger, or may simply withdraw and cease to exhibit much behavior at all. Finally, individuals who are abused or

neglected will be especially prone to learn maladaptive behavior in his/her struggle to survive conditions over which he/she has no control.

The Definitions section categorizes procedures to reduce/eliminate behavior into three sections: mild procedures to reduce behavior, moderate procedures to reduce behavior, and aversive procedures to reduce behavior (IIC). The Task Force, employing the least drastic alternative principle, believes that mild procedures should be tried and failed in treatment programs before using moderate procedures, and moderate procedures tried and failed before using aversive procedures. The chart on the following page illustrates the differences between these three levels of procedures, and because these distinctions reflect the most important issues in these guidelines, they will be discussed here in some detail.

It is important to note that this categorization scheme is similar to that used by a number of other states who have developed behavioral procedure guidelines.

Mild procedures (differential reinforcement, extinction, correction) involve actively reinforcing adaptive behavior while ignoring or minimally consequencing maladaptive behavior. They present a low potential for abuse, are extensions of normal social interactions, and properly taught can be used routinely by direct care staff. Moderate procedures (exclusion time-out, fining, positive practice) are most intrusive and are adaptations of socially acceptable means of controlling behavior. They are used for behavior problems which significantly interfere with a client's learning or his/her social interactions, and should be designed and supervised by a person familiar with behavioral programming and with the specific techniques. Aversive procedures involve the application of stimuli that a client finds physically or psychologically painful contingent upon presentation of targeted maladaptive behavior. Examples are noxious smells and tastes, electric shock, seclusion time-out, and physical restraints when used as part of treatment rather than as an emergency procedure. They have a high potential for abuse, and can be designed and supervised only by a psychologist or a physician, where the client's behavior presents a danger to himself or others.

The Task Force subscribed to a hierarchy of treatment model for retarded persons with serious behavior problems. In this model,

Procedures to Reduce Behavior: Explanatory Chart

Category of Procedures	Characteristics	Examples	Good For Which Behavior Problems	Who Develops the Procedures?	Review and Approval
Mild procedures to reduce behavior	-Active reinforcement of adaptive behavior skills ignoring or minimally punishing maladaptive behavior -Definements of normal social interaction -Low potential for abuse	-Differential reinforcement -Extinction -Overcorrection -Environmental alterations	Maladaptive behavior of all kinds	-Used in context of early habilitation training -Program director responsible to insure relevant habilitation plan -Used routinely by direct care staff trained in procedures	-Developed and implemented by program director -Used in mild procedures noted in hab plan -Prior notification or approval of procedure unnecessary
Moderate procedures to reduce behavior	-Removal of reinforcers contingent upon presentation of targeted maladaptive behavior-includes restriction in appropriate alternative -Definements of normal methods used to control behavior -Potential for abuse	-Extinguish observation -Seclusion time-out -Fading/response cost -Positive practice -Exercise restriction	-Maladaptive behavior which significantly interferes with learning and/or social interaction -Including dangerous behavior -Mild procedures tried and failed	-Behavior targeted and treatment plan developed under program director supervision -Behavioral consultant used if necessary -Implemented by program staff under program director supervision	-Approved by IOT -Office of Laboratory certified of IOT meeting and decision
Severe procedures to reduce behavior	-Application of stimuli that elicit (from physically or psychologically painful) aversive contingent upon presentation of targeted maladaptive behavior -Unconventional methods of controlling behavior -High potential for abuse	-Electric stimuli -Seclusion time-out -Severe overcorrection -Personal restraint -Mechanical restraint	-Maladaptive behavior more harmful to the client than the treatment program -Behavior that is dangerous to the client or persons around him/her -Mild and moderate procedures demonstrated as tried and failed	-Designed by psychiatrist or physician trained in aversive programming -Carried out by staff under the supervision of designated professional -Physician checks on effectiveness of procedure and treatment	-Approved by IOT with informed consent of client and/or client representative -Approved by facility director -Reviewed and approved by external review committee (depending on client may be Special Committee on Severe Conditioning, Abuse, or Human Rights Committee) -Program director notified

BEST COPY AVAILABLE

treatment programs are designed so that mild procedures are tried and found ineffective before trying moderate procedures, and moderate procedures tried and failed before trying aversive procedures. This model does not imply that every mild procedure must be tried before using an aversive procedure, because a number of procedures will just not be sensible for an individual client. The model does specify that appropriate less drastic procedures will be attempted before more drastic.

These guidelines reflect a belief that there is a place for moderate and aversive procedures in treatment, where:

- a) the severity of the problem exceeds the severity of the treatment;
- b) qualified persons are available to design and oversee the treatment program;
- c) there is external review of the proposed treatment program by objective persons outside of the treatment situation. The more aversive the procedure being proposed, the greater the amount of external review.

The step-by-step process by which these factors are weighed in individual treatment programs as outlined in Section III: Review and Approval of Behavioral Programs.

- 4) **Emergency Procedures** which involve confining a client or restricting his/her movement over time. Examples include seclusion timeout, mechanical restraint, personal restraint and exclusion timeout. Maine law classifies such procedures as restraints, and states that they can only be used to protect a client from imminent injury to self or others (34 MRSA 2143-13).

Restraints are used primarily in emergencies as a staff response to dangerous client behavior. They may also be used in treatment as behavioral procedures, when employed in a planned and systematic way contingent on a targeted maladaptive behavior. Whether used in a planned or impromptu way, however, they are subject to those laws and regulations covering restraints.

These procedures are covered, therefore, in two sections of the guidelines. First, they are listed and categorized as behavioral procedures in the Definitions section, with a notation of those classified

as restraints. Secondly, a special section IIC-4 describes restraints in detail, clarifying some differences in laws and regulations, applicable to sub-groups of mentally retarded persons (e.g. ICF/MR residents, community Class Action members, and non-Class Action members).

D) QUALIFICATIONS OF PERSONNEL

For the purposes of these guidelines, three kinds of job roles will be considered:

- 1) professionals who serve as part of a client's interdisciplinary team and who may design/supervise treatment programs - psychologists, psychiatrists, and physicians,
- 2) program directors, including qualified mental retardation professionals (QMRP), who are responsible for supervising client's prescriptive program plans, and
- 3) direct care staff who implement client programs. The qualifications and job functions of monitoring personnel such as BMR designated case managers, IPP coordinators and advocates are specified in other Department policies and regulations and will not be duplicated here.

1) Behavioral Treatment Professionals

- a) Maine law (34 MRSA 229-2652-J) defines a professional as a person licensed by the State of Maine to practice medicine or psychology and who has had training and experience in the diagnosis and treatment of mentally retarded persons. The specific qualifications for Maine licensure as a psychologist or physician are determined by each profession's licensing laws and boards of examiners.
- b) It is required for each BMR client that a professional be part of the interdisciplinary team that 1) comprehensively evaluates that client, and 2) formulates an individual prescriptive program (34 MRSA 229-2652-GI).
- c) For class members at Pineland, psychological evaluations are required annually (Appendix A, Section J). For community class members, psychological evaluations are required every three

years, and psychological reviews every year (Appendix B, section D-8). It is recommended this latter level of evaluation be available to non-class members.

- d) It is recommended that preventive psychological services aimed at personal and social growth be considered. In addition to behavioral approaches, psychotherapeutic approaches including individual, group and family counseling may be appropriate with some clients.
- e) It is required that treatment programs involving aversive procedures be designed by a psychologist or physician (34 MRSA 2143-12). For class members, it is more specifically required that aversive programs be designed and supervised only by a psychologist or psychiatrist who has had proper training in the use of such techniques, and who is specifically authorized by the BMR director to conduct such aversive conditioning (Appendix A, section P; Appendix B, section F-7). It is strongly recommended that professionals employing aversive programs for any BMR client demonstrate proper training in the use of aversives and be authorized by the BMR director to conduct aversive programs. Furthermore, it is recommended that the BMR director consult appropriately trained psychologists and psychiatrists in making determinations about the prerequisite training necessary to conduct aversive treatment.
- f) It is required that a physician examine a client for whom a behavioral treatment program to eliminate bizarre or unusual behavior is proposed to rule out the possibility that such behavior is organically caused (34 MRSA 186-A 2143-12). It is mandatory that this examination also evaluate the safety of the proposed treatment in terms of the client's physical health.
- g) For class members, it is required that physicians prescribing psychotropic medication to clients monitor the effects of this medication as specified in Appendix A, Section O; Appendix B, section D-2.

2) Program Directors

- a) For the purposes of these guidelines, the term program director will mean the administrator responsible for the facility, residence or program where the behavioral treatment will be carried out, or

or that person's delegated representative. At ICF/MR facilities, that person will be the QMRP except in the specific situations where facility director approval is required. In community residences or programs, that person will be the administrator of that residence or program.

b) 1. An ICF/MR must have a QMRP who is responsible for:

- a. supervising the delivery of each resident's individual plan of care;
- b. supervising the delivery of training and habilitation services;
- c. integrating the various aspects of the ICF/MR's program;
- d. recording each resident's progress; and
- e. initiating a periodic review of each individual plan of care for necessary changes.

2. Qualifications for the QMRP are specified in section 6.N.1 of the Maine ICF/MR regulations.

c) It is recommended that the program director be responsible for design and implementation of treatment programs employing moderate procedures to weaken behavior when she/he has the experience with these procedures. When, in the opinion of the IDT, she/he does not have sufficient competence and the IDT has identified the need for behavioral treatment beyond teaching and mild procedures, it is recommended that a psychologist with appropriate training be located to design and supervise the program.

3) Direct Care Staff

a) Pineland and other ICF/MR staff are required to receive, as part of their 44-hour orientation, training in developmental programming, habilitation and behavior modification. It is also required that ongoing training be available in behavior modification (Appendix A, section E-4; ICF/MR regulations 11.H.2).

b) There are no similar requirements for staff in other community

residences or programs, although Appendix B, section I specifies that operators or managers of homes or programs that serve a preponderance of class members receive training recommended for Pineland staff.

- c) It is further recommended that specialized training be made available to staff working in facilities or programs where moderate and aversive procedures to weaken behavior may be utilized regularly, and that BMR eventually develop a certification process for persons implementing aversive programs. This training would be over and above the program - specific training provided by a psychologist or psychiatrist supervising an aversive program.
- d) It is recommended that these guidelines be part of the orientation and training of new staff in facilities, residences and day programs, and they directly address training areas specified in the ICF/MR regulations and Consent Decree.

Section II

Definitions of Behavioral Procedures

A) PROCEDURES TO TEACH NEW BEHAVIOR

As noted previously, the Task Force believes that behavioral programming provides a very effective means to teach mentally retarded persons new skills. Behavioral programming utilizes the procedures defined below with the organizational context specified in section IC.

- 1) **Task Analysis** has two parts-content and process. Content task analysis is the division of a given skill or task into teachable steps. Process task analysis is the specification of the assistance the teacher will provide to insure that the learner will perform these steps. Process task analysis includes decisions about format and feedback, described just below and reinforcement, described in section IIB. Task analysis requires the teacher to clearly conceptualize what the learner will do to show he/she has learned a skill, and what methods the teacher will use.
- 2) **Format** describes the way in which the steps of the task will be presented. Examples of formats include chaining (presentation of a single step until learned, then the next step until learned, then the next step) and total task presentation (repeated presentation of all steps until learned). There are formats for single pieces of learning such as match-to-sample, discrimination, paired association and oddity. Finally, there are formats called organized exposure or simulation where behavior is practiced in a controlled environment is shaped to become increasingly like the environment where the behavior is expected to occur (e.g. practicing job interviews at the sheltered workshop prior to a real-life interview).
- 3) **Feedback** is letting the learner know what he/she should do and when he/she has done it correctly. Feedback can be given verbally, by modeling or gestures, or by physical assistance (such as hand-over-hand) and these words, gestures, or actions are sometimes called **prompts**. Initially the learner is prompted as much as is necessary to get him/her through the task and these prompts are systematically **faded** over time until the learner performs the skill at the appropriate time and place without any teacher input.
- 4) **Shaping** is the rewarding of the learner for successive approximations of the target skill. For example, if the teacher wants the

learner to say "ball" she may reward, at first, any vocalization. After the learner has begun vocalizing, the teacher reinforces behavior that more closely approximates the target behavior, perhaps the "b" sound. The process continues until the target behavior is performed.

B) PROCEDURES TO STRENGTHEN BEHAVIOR

Procedures for strengthening behavior are used to increase the rate of a behavior currently in an individual's repertoire and also to insure that the behavior occurs at the appropriate time and place.

Strengthening behavior is accomplished by providing positive consequences or reinforcers after a desirable behavior occurs. It is important to note that while general statements can be made about what people or groups of people find reinforcing, there is a good deal of variation as to what an individual likes or does not like.

- 1) **Intrinsic reinforcement** refers to acts that produce their own rewards, that individuals do because they enjoy them, and not because of any subsequent payoff. Depending on the individual, examples may include physical activities, hobbies, certain tasks at work, or conversation with other people. Intrinsic reinforcements are especially important to good programming, as they imply that the client is performing the behavior in a natural environment without additional reinforcement.
- 2) **Social reinforcement** refers to the response of other persons to the client presenting the behavior. The positive attention of another human, expressed in words, physical contact, or smiles, is a very powerful reinforcer, and a key part of the natural reinforcement system we have in normal everyday life. There are some clients for whom social attention is not a reinforcer, and special procedures can be devised to pair social reinforcers with other preferred reinforcers. The Task Force takes the position that positive social interaction between staff working with retarded persons and the clients is a primary and critical prerequisite to any effective program of habilitation.
- 3) **Artificial reinforcement** refers to contrived arrangements where clients receive awards, activities or tokens to be exchanged for reinforcers contingent upon appropriate behavior. Examples of rewards and activities might include going out to the movies after

completing a lesson, or extra time to listen to music. The reward can also be a token which is then exchanged by the individual for other reinforcers. Tokens are often employed as part of a token economy where clients receive tokens for a wide variety of appropriate behaviors. In view of this Task Force, token economics should be used as a means to a defined objective and should not become the objective itself. That is, they should be implemented along with defined procedures to phase into natural reinforcement systems.

- 4) **Appetitive reinforcement** is the use of food and/or drink to reinforce desired behavior. These reinforcers are powerful, and can be used when the individual is not amenable to other reinforcers. They should also be paired with social or intrinsic reinforcers and phased out over time, so that the client is eventually operating in a natural reinforcement system. Using food as positive reinforcement implies that this food will be provided in addition to a nourishing, well-balanced diet served at normal times of the day. Denial of a nutritionally adequate diet cannot be used as part of a behavior modification program (34 MRSA 186-A 2143).

C) PROCEDURES TO REDUCE BEHAVIOR

As noted above, procedures to reduce behavior are divided into three categories: mild procedures to reduce behavior, moderate procedures to reduce behavior, and aversive procedures to reduce behavior.

1) Mild procedures to reduce behavior

- a) **Extinction** is the withdrawal of reinforcement from behavior that has been previously reinforced. An example is ignoring a client when he is making odd noises. Extinction is usually used in combination with differential reinforcement, so that appropriate behavior is being shaped to replace inappropriate behavior.
- b) **Differential reinforcement of incompatible behavior (DRI)** involves specifying one or more target behaviors which are incompatible with the undesirable behaviors, and consistently reinforcing these target behaviors. An example is reinforcing a client for chewing gum rather than eating inedible objects.
- c) **Differential reinforcement of other behavior (DRO)** consists of

presenting reinforcement to an individual after a set period of time in which a targeted maladaptive behavior has not occurred. An example is the provision of food after five minute intervals when a client does not put his/her hand into his/her mouth.

- d) **Differential reinforcement of low rates (DRL)** involves reinforcement after a specified period of time only if the target maladaptive behavior has occurred fewer times than a previously established number of times. It is similar to DRO and useful with behavior which is inappropriate only if it occurs too often or too rapidly. An example is praise for a workshop trainee who only shakes hands once with his supervisor in the morning instead of many times.
- e) **Correction** is a procedure in which an individual who disrupts his/her social or physical environment is required to restore that environment to its previous normal state. Examples include directing an individual to clean up milk he has deliberately spilled or to apologize to another resident he has hit. Correction is a milder form of positive practice over-correction and aversive over-correction procedures, which are more drastic procedures because they involve extensive practice of incompatible behavior as consequences for disruptive behavior. Positive practice over-correction and aversive over-correction are discussed under moderate procedures and aversive procedures, respectively.
- f) **Environmental alteration** is the alteration of an individual's environment to take away the opportunity to perform an inappropriate behavior or lessen its negative impact. An example is separating two students at an activity program who often fight when they have to sit next to each other. This procedure should not be used to deprive clients of basic rights or the opportunity to meet basic needs (e.g. clients should not be removed from day programs just because they are disruptive, or told to eat by themselves because they eat sloppily).

2) Moderate procedures to reduce behavior

- a) **Contingent observation** (also called non-exclusionary time-out) is a procedure in which a client contingent upon a targeted behavior, is directed to move back from current activity to another part of the room to watch. He/she calms down while observing appropriate behavior being reinforced. The client is

asked to rejoin the activity when he/she is composed and gives a word or gesture that he/she is ready to behave appropriately. It is effective where clients find the situation from which they are removed to be reinforcing. Contingent observation is a form of time-out, but differs from exclusion or seclusion time-out in that the client remains in the same room where the target behavior occurred, and he/she is shown appropriate alternatives to this behavior. It usually takes five to fifteen minutes and should not take more than one hour.

b) **Exclusion time-out** is a procedure in which a client is removed from an environment where enforcement is available, contingent upon targeted maladaptive behavior, and placed in a room or area that is part of his/her normal living environment or an unlocked room designed for time-out purposes. It includes procedures such as sending clients to their bedroom, or sit in an extra classroom. Once in time-out, a client should be checked on regularly to see if he/she is safe and willing to return to activity. The procedures should not last for more than one hour. For community class action suit members, exclusion time-out is classified as a restraint, and, therefore, can only be used for target behavior that is dangerous to self or others. See section IID on restraints. Exclusion time-out (ETO) differs from seclusion time-out (STO) in that the time-out room is never locked in ETO and is in STO.

c) **Response cost**, also called **fining**, is a procedure that involves withdrawing from an individual a specified quantity of reinforcers that an individual normally has or uses, contingent upon targeted maladaptive behavior. The individual is then presented with the opportunity to earn back these reinforcers and more contingent upon appropriate behavior. The procedure can be used with a single targeted behavior consequenced by the withdrawal of specified reinforcers or within a restrictive token economy, providing a complex system of rewards and fines for a variety of targeted adaptive and maladaptive behaviors. This procedure should never be used to infringe upon a client's basic needs, but rather utilize reinforcers such as treats, special trips and outings, or specific leisure time activities. Admittedly, there is some gray area here as to where some of these reinforcers end and violations of rights begins. In classifying response cost as a moderate procedure, the Task Force believes that these distinctions are best made by an IDT with client approval (or authorized

client representative approval for incompetent clients) and participation of a departmental advocate.

- d) **Positive practice over-correction**, also called **positive practice**, is a procedure in which an individual is required, contingent upon targeted maladaptive behavior, to practice behaving correctly with the practiced behavior being a similar but appropriate version of the target behavior. Where the physical or social environment has been disrupted, the individual is required to correct the damage by returning the environment to better than its normal state (hence "over-correct"). For example, an individual who smears on a bathroom wall may be required to clean the entire bathroom. This positive practice aspect of this procedure is also used where the environmental damage is minimal, with behavior such as hand-biting, stereotypic movement, rumination and pica - and may involve restricting the movement of a part of the body to prevent targeted behavior. The procedure should not take more than fifteen minutes, nor should it involve physically forcing a resistant client through the practice session. If either of these factors is present, the procedure becomes aversive - aversive over-correction is discussed below.

3) **Aversive procedures to reduce behavior**

Aversive procedures are defined as the systematic application of stimuli that a client finds physically or psychologically painful contingent upon target maladaptive behavior. They include those procedures described in the Consent Decree as aversive conditioning and those described in 34 MRSA 186-A as treatment programs involving the use of noxious and painful stimuli.

- a) **Aversive over-correction** has the same basic characteristics as positive practice over-correction, and in addition:

- takes longer than fifteen minutes (usually 30 minutes);
- may involve extensive physical guidance of a resistant client.

There are educational elements and aversive elements to all forms of over-correction. The distinctions drawn here (amount of time and amount of guidance) mark a shift between a procedure which is primarily educational and a procedure which is primarily aversive. See Appendix B for a letter from Dr. Richard

Foxx, the inventor of the procedure, for further clarification. Aversive over-correction should not occur for more than forty-five minutes, nor cause physical injury to a client.

b) **Seclusion time-out** is a procedure in which a client is removed, contingent upon targeted maladaptive behavior, and placed in a locked room or any locked room or any locked setting such as closet or box. Maine law 34 MRSA 186-A specifies that seclusion can be used only to protect a client from dangerous behavior to self or others, that staff must check the client at least every ten minutes, and that the procedure should never occur for more than one hour. There are other more stringent restrictions on the use of seclusion for specific sub-groups of BMR clients such as class members and ICF/MR residents. See section IID on restraints for clarification.

c) **Personal restraint** is a procedure where a client is placed in a supine position, held in a chair or otherwise restricting movement of the body for up to an hour as a consequence for targeted maladaptive behavior. It can only be used to protect a client from behavior that is dangerous to self or others. See section IID on restraints for further specification of the kinds of mechanical restraints which can be used in specific settings with specific groups of BMR clients.

e) **Noxious stimulation** is the application of a noxious stimulus contingent upon the presentation of a targeted maladaptive behavior. These stimuli include smells, tastes or sounds the client finds noxious, contingent upon slapping, and contingent electric shock. Maine law (34 MRSA 186-A 2143-12) specifies that treatment programs involving the use of noxious or painful stimuli may only be employed to correct behavior more harmful to the client than the treatment program. Noxious stimulation is always utilized to quickly suppress dangerous behavior so that other forms of therapy can be implemented.

D. RESTRAINTS/EMERGENCY PROCEDURES

1) General Points

a) There are a number of procedures which involve confining a client or restricting his/her movement, which are classified under Maine law as restraints. These are seclusion time-out,

exclusion time-out, and two types of physical restraint: personal restraint and mechanical restraint. These are used both in emergencies and as part of behavior treatment programs, but are considered restraints in either circumstance.

- b) Generally, all of these procedures can only be used to protect a client from imminent injury to self or others (34 MRSA 186-A 2143 11, 13; Consent Decree: Appendix A, section N; Appendix B, section F-7). There are a few exceptions to this with exclusion and seclusion time-out, which are described below.
- c) Restraints should never be employed as punishment, for the convenience of staff, or as a substitute for habilitative services (34 MRSA 186-A 2143 13).
- d) Maine ICF/MR facilities have a written policy that specifies:
 - how and when physical restraints may be used;
 - the staff members who must authorize use;
 - the method for monitoring and controlling use.

The Task Force recommends that other facilities and programs for mentally retarded persons develop similar written policies. The Task Force also recommends that seclusion time-out be included within these policies.

- e) There are some differences between laws and regulations applicable to sub-groups of BMR clients (Pineland residents, community class members, clients in ICFs and ICF/MRs, clients who are neither class members nor ICF/MR residents).

2) Seclusion time-out (locked room)

- a) Locked room seclusion involves the placement of a client in a locked room whether that room is specifically designed for time-out purposes or a room used for other purposes (34 MRSA 186-A 2143 11). Locked room seclusion should never last more than an hour, be used only to protect the client from imminent injury to self or others, and staff should make visual checks every ten minutes. For Pineland and all other ICF/MR residents, constant visual surveillance is required (Maine ICF/

MR regulations 42 CFR § 442.437).

- b) For community class members, locked room seclusion is forbidden, except under the supervision of BMR crisis intervention teams (Appendix B, section F-7). This requirement applies to community class members living at ICF/MRs other than Pineland.
- c) It is required of Pineland staff (Appendix A, section N-11) and recommended for all service providers allowed to use this procedure that less restrictive measures be tried first, and failure of these measures documented.
- d) It is required that daily reports on the use of locked room seclusion and other restraints be made to a facility administrator and a monthly summary of these reports be sent to the Office of Advocacy (34 MRSA 2143 13). For Pineland residents, the client's correspondent should also be notified (Appendix A, section N-7).

3) Exclusion time-out

- a) Maine law regulations make a primary distinction between locked room time-out (seclusion) and other forms of time-out in unlocked rooms (which in the guidelines are defined as contingent observation and exclusion time-out). Maine law does not distinguish between time-out in a natural setting from time-out in rooms specifically designed for time-out purposes although the Task Force recognizes that the former is less restrictive than the latter.
- b) For ICF/MR clients, exclusion time-out is permissible for other behavior problems for periods of up to an hour as part of a behavior modification program approved by the facility's QMRP or Human Rights Committee (Maine ICF/MR regulations 9.1.).

4) Physical restraints: mechanical

- a) Mechanical restraints include helmets used as restraints, mitts, restraint typing devices, camisoles, totally enclosed cribs, and barred enclosures.

- b) For all mentally retarded persons, physical restraints should impose the least possible restriction consistent with their purpose and should be removed when the emergency ends. Restraints should not cause physical injury to the client and shall be designed to allow the greatest possible comfort (34 MRSA 186-A 13). For ICF/MR residents, staff must check a resident placed in restraint every thirty minutes, and provide an opportunity for exercise for a period of at least ten minutes during every two hours of restraints (Maine ICF/MR regulations 9.F.).
- c) It is required for all ICFs that physical restraints be ordered by a physician. It is required of ICF/MR facilities that this order not be in effect any longer than twelve hours (Maine ICF/MR regulations 9.F.), for ICFs that they not be in effect for more than sixty days (Maine Regulations for Skilled Nursing Facilities and ICF, section 15D2).
- d) It is required for ICF/MR residents (Maine ICF/MR regulations 9.F.) and strongly recommended for all BMR clients that strait-jackets and camisoles never be used, and that clients never be tied, spread-eagle to a bed.
- e) For ICF/MR residents and class members, it is required that there be documentation of the failure of less drastic alternative procedures before physical restraints be undertaken (Maine ICF/MR regulations 9.F.; Appendix B, section F-7). It is recommended that this process be followed for use of restraints for all BMR clients.
- f) It is required for BMR clients for whom restraints are being used, that daily reports be made to the facility or program director, and that a monthly summary of these be relayed to the Office of Advocacy.
- g) Nothing prescribed here shall preclude the use of normative devices for medical purposes.

5) Physical restraints: personal

- a) Personal restraint, defined as holding an individual for periods up to one hour, is explicitly classified as a restraint for ICF/MR residents and class members (Maine ICF/MR regulations 9.F.; Appendix B, section F-7). It is, therefore, subject to the same

regulations as other physical restraints used only to protect the client or others from imminent injury, less drastic alternatives documented, and reported to the Office of Advocacy. It is recommended that these regulations also be followed with all other BMR clients.

E) PROCEDURES NOT COVERED BY THESE GUIDELINES

The above list of procedures are those most widely used in behavioral programming which have been empirically tested by behavioral research and found to be effective. The Task Force recognizes that new behavioral procedures are being developed every year, and that this list may not prove to be exhaustive. In recommendations submitted separate from these guidelines to the BMR director, the Task Force will recommend that the director appoint a team of behavior and legal experts and consumer advocates to review the guidelines yearly and make any necessary modifications or updates.

If, in the meantime, there arise questions about the definition of and proper categorization for a specific procedure being contemplated for an individual client, these should be referred to the BMR director, who makes these determinations after making appropriate professional consultation.

Section III

Review and Approval of Behavioral Programs

A) GENERAL POINTS

- 1) The Bureau of Mental Retardation (BMR) is legally mandated to provide a system of care that meets the basic needs of retarded persons while protecting their legal and human rights (34 MRSA 186-A 2147). Behavioral programming can provide effective methods for helping BMR and BMR service providers in meeting some of those needs.
- 2) BMR has developed an Individual Prescriptive Program process to insure that client needs are met in a rational and humane way. The Task Force believes that the behavioral procedures defined in section IIA, IIB, and IIC-1 can be utilized and sufficiently monitored by BMR through its IPP process. These are teaching procedures, procedures to strengthen behavior, and mild procedures to reduce behavior. The steps to this review process are outlined below.
- 3) Moderate and aversive procedures to reduce behavior present greater risk to a client because of their intrusiveness, because they may involve control of his/her personal possessions, confinement or restraint, or the application of noxious or painful stimuli. It is, therefore, necessary that they be closely scrutinized prior to implementation. Other agencies in addition to BMR, with responsibility for protecting human and legal rights become involved in the review process including the Department Office of Advocacy, and depending on the procedure and the client, the Special Committee on Aversive Conditioning or a facility Human Rights Committee.
- 4) Aversive programs which constitute the greatest risks to clients require review and approval by an external review committee over and above IDT approval and informed client or client representative consent. For class members, this is the Special Committee on Aversive Conditioning, for ICF/MR resident, the Human Rights Committee, and for other mentally retarded persons, the Office of Advocacy.

B) REVIEW AND APPROVAL OF PROGRAMS USING HABILITATIVE PROCEDURES OR MILD PROCEDURES TO REDUCE BEHAVIOR

- 1) IDT develops yearly Individual Prescriptive Program identifying client needs, program goals and objectives within specific time frames (required for all BMR clients (34 MRSA 229 2651)).
- 2) The IPP should include identification of serious problems with a plan to reduce these problems, which utilizes mild procedures to reduce behavior while teaching adaptive behavior. For class members, it is required that self-abusive or regressive behavior be noted and addressed (Appendix A, section D-7; Appendix B, section B-10). For community class members exhibiting behavior that jeopardizes home or day program placement, it is required that crisis intervention services be provided prior to removal (Appendix B, section D-3).
- 3) IPP approved by all involved parties including client and/or authorized client representative.
- 4) Programs are implemented and internally monitored by service providers. BMR monitors plan and programs on a quarterly basis.

C) REVIEW AND APPROVAL OF PROGRAMS USING MODERATE PROCEDURES

- 1) IDT identifies that client is presenting one or more serious behavior problems, even when the solid habilitation programming described above is in place. IDT documents that reinforcement and mild procedures have been tried and failed.
- 2) A person deemed as qualified by the IDT designs a behavior program which includes moderate procedures to reduce behavior. This will usually be the qualified mental retardation professional, the program director or a psychologist.
- 3) Program is approved at yearly or modified IDT meeting including informed consent of client and/or authorized client representative.
- 4) The Department client advocate is notified prior to the IDT meeting that a moderate procedure is being considered, and invited to attend. After the program is approved and the advocate is notified, if necessary, that program is implemented.

D) REVIEW AND APPROVAL OF PROGRAMS USING AVERSIVE PROCEDURES

1) IDT team identifies problem behavior/authorizes design of treatment program

- a) IDT identifies that client is presenting one or more serious and dangerous behavior problems, and that the solid habilitation programming described above is in place.
- b) IDT documents that positive reinforcement and less drastic procedures have been tried and failed (required for class members (Appendix B, section F-7), ICF/MR regulations 9.1.), and recommended for all BMR clients)). Less drastic procedures should include both mild and moderate procedures to reduce behavior.
- c) IDT designates a psychologist or a physician to develop a treatment program. It is required that a client and/or his/her authorized representative be invited to attend meetings addressing this treatment (34 MRSA 2656 6), and also required that a client's advocate be invited to these meetings.

2) Client is professionally evaluated and a treatment program designed based on this evaluation

- a) Physician examines client to rule out the possibility that these behaviors are organically caused (required by 34 MRSA 186-A 2143 12). It is also recommended that the physician insure that this time that the proposed treatment is not medically contraindicated for the client.
- b) The psychologist or physician designs a treatment program which may include aversive procedures (34 MRSA 186-A 2143 12). For class members, aversive procedures can only be designed by a licensed psychiatrist or psychologist trained in these techniques who is specifically authorized by the BMR director to conduct aversive conditioning. (Appendix A, section F; Appendix B, section F-7).
- c) It is recommended that the professional designing the program utilize the standards of good practice described in the definitions and design/implementation section. This should include expected treatment outcomes to be accomplished within a stated time.

3) The IDT team, including client or client's legally authorized representative, reviews and approves the treatment program

- a) It is required that the IDT approve all major changes in program, including aversive treatment programs for all BMR clients (34 MRSA 229 2656 6).
- b) It is required that all aversive treatment programs occurring within a given residential facility or program be approved by the director of that residential facility or program (34 MRSA 186-A 2143 12).
- c) Informed consent to the treatment program must be given by the client or client's legally authorized representative if the client is unable to give informed consent. This is required for all class members (Appendix A, section P; Appendix B, section F-7) and recommended for all BMR clients. It is recommended that the model informed consent form (Appendix C) be used in obtaining consent for all aversive treatment programs.

4) The treatment program is reviewed and ratified by an external review committee

- a) Aversive treatment programs for class members must be approved by a special committee on aversive conditioning designated by the BMR director which includes the client's advocate and representation from the Consumer Advisory Board (Appendix A, section P; Appendix B, section F-7).
- b) It is required for ICF/MR facilities that either the Human Rights Committee or the qualified mental retardation professional approve aversive programs. It is recommended that the Human Rights Committee review and monitor all aversive treatment programs occurring within its facility.
- c) For BMR clients who are not class members, the Departmental advocate serves as the external reviewer (34 MRSA 186-A 2143 12).

5) Notification of appropriate persons

The external review group (or person) notifies the IDT of its decision. For community class members, if treatment is approved, the

IDT notifies the BMR director, and for Pineland residents, the Superintendent of the facility (Appendix A, section P; Appendix B, section F-7). It is recommended that the director be notified by the Office of Advocacy of approval of aversive treatment programs for non-class members.

6) The program is implemented under the supervision of the designated professional

Program implementation will be the responsibility of the professional identified in the treatment proposal. The necessary training to carry out the specifics of program intervention and data-keeping should occur under the supervision of this professional. It is required that psychologists implementing treatment programs at Pineland maintain at least weekly contact for the first month of the program, and monthly thereafter (Appendix A, section J), and recommended that this be a minimum supervisory requirement for professionals implementing an aversive treatment program for all BMR clients.

7) Program monitoring

It is recommended that both the IDT and external review committee monitor the treatment within one month of its inception and bi-monthly after that, to evaluate 1) whether the treatment has been implemented, 2) whether the treatment is working, and 3) less drastic treatment is now appropriate. The supervising professional will be responsible for providing necessary written information to the team and external review committee.

Appendix A

STATEMENT ON DISCIPLINE

Discipline, in the broadest sense of the word, can be defined as the training and learning required to assist an individual in moving himself to a higher level of maturity, or to assist him in fulfilling his potential. In this sense education, habilitation, and guidance which is self-initiated or which is derived from others can be seen as discipline. In this broad sense, it is inaccurate and inappropriate to look upon discipline as solely a negative, restrictive, phenomenon imposed by others.

When a child is born, he is lacking in control over self. He is non-ambulatory, incontinent, and unable to dress, feed or wash himself. He possesses virtually no internal controls, but he must be controlled or cared for by an external source (the parent or parent surrogate) or he will die. As the child grows older, a shift gradually occurs in the focus of control over the self (Fig. #1). He begins to internalize controls and determine the direction of his own life. He learns to roll over, crawl, walk, and then to run at will; he learns to hold his bottle, eat with his fingers, use spoon, fork and then knife at will. And so it goes, the more mature a child becomes the less he is reliant upon external controls, and the more his behavior is determined by "self" control.

A continuum exists in these **Guidelines** that begins, on the one hand, with procedures for establishing behavior (IIA); and for strengthening behavior (IIB) procedures that can be a part of normal, everyday learning and growing. At the other end of the continuum are the aversive procedures to reduce behavior. These procedures, since they may eventually lead to increased maturity and growth, may also be viewed as a form of discipline by some. However, for the **purposes of these Guidelines**, the term discipline will only apply to those procedures that fall within the categories of procedures for 1) establishing behavior, 2) strengthening behavior, and 3) mild procedures for weakening behavior, as well as other procedures that are commonly used by humane caregivers that do not violate the law (examples: physical guidance, verbal direction).

This is to say that the procedures for establishing behavior and the procedures for strengthening behavior can be adapted to function as important, everyday disciplinary techniques that may be a part of every mentally retarded individual's life. They are essential in assisting the individual to learn behavior that will move him further along the path toward maturity and independence (the relative absence of external controls). As well, the mild procedures to reduce behavior, and other pro-

cedures that are commonly used by humane caregivers that do not violate the law, would normally be a part of every individual's life as he learns more appropriate ways of behaving.

Again, it is the position of the Task Force that the severe procedures to reduce behavior do not fall under the category of discipline. These procedures, though they may eventually lead to increased maturity and growth, are not to be considered disciplinary techniques, but are intrusive approaches to changing behavior that must be monitored and applied according to the standards set forth herein. Moderate procedures to reduce behavior are also not to be considered forms of everyday discipline for the purposes of these **Guidelines**. These procedures are also to some degree intrusive upon the rights and freedom of the individual and must be monitored by that level of "due process" stated herein.

The delicate demarcation between what is everyday discipline and what is an intrusive behavioral procedure must be determined not only by how methodically it is applied and who has license to apply it, but by reference to the questions below:

- 1) Frequency - How often is the technique used?
- 2) Duration - How long is the technique used for?
- 3) Intrusiveness - How contrary to the free exercise of an individual's will is the technique?

If there is any doubt as to whether the technique under consideration falls within that portion of the continuum defined as discipline or of more intrusive behavioral procedures based upon the above criteria, then the decision to use that technique should be deferred to the individual's next IDT staffing.

Maine law 34 MRSA 186-A 2143 specifies that facilities prepare a written statement of policies and procedures for the control and discipline of residents directed toward the goal of maximizing the growth and development of these clients. The Task Force recommends that other residences and programs develop discipline policies that clarify proper interactions between staff and clients which are not specifically behavioral procedures.

Appendix B

umbc

UNIVERSITY OF MARYLAND BALTIMORE COUNTY
Calonsville, Maryland 21228

Department of Psychology 301-455-2567

February 7, 1980

Dr. Gerry Tracy, Coordinator
Community Education - Northern Resource Center
51 Broadway
Bangor, Maine 04401

Dear Dr. Tracy:

In answer to your letter of January 8, 1980. Your understanding of over-correction is excellent. I have included some reprints for your files that discuss overcorrection.

1) In terms of degree of aversiveness, I would place overcorrection with the punishment procedures in the following manner:

non-exclusionary timeout
timeout-overcorrection
physical restraint (aversive not punishment)
electric shock, slap, etc.

Thus, overcorrection is between a moderate and severe procedure to weaken behavior depending on its duration, i.e., under 15 minutes moderate, over 15 minutes severe.

2) All overcorrection procedures could be used by direct care staff without extra supervision provided: a) that they are occasionally checked by a psychologist, and b) that they have been certified in each overcorrection procedure. By certified I mean that each staff person has demonstrated clinically that he/she can conduct the procedure, i.e., the psychologist has trained then watched them.

I do not differentiate between the types of overcorrection in terms of their aversiveness, but rather do it on the basis of the length of the procedure. Incidentally, some short duration overcorrection procedures have been very effective, e.g., the oral hygiene (tooth brushing) procedure for biting, rumination and pica.

I hope that you find the above information helpful. Best wishes with your guidelines and thanks for giving me the opportunity to provide you with some input regarding overcorrection.

Sincerely,

Richard M. Fox

Richard M. Fox, Ph.D.

RMF/th

Appendix C

DATE: _____

**INFORMED CONSENT FORM FOR MAINE BUREAU OF MENTAL
RETARDATION CLIENTS RECEIVING TREATMENT
INVOLVING AVERSIVE CONDITIONING**

NAME _____ TREATMENT LOCALE(S) _____

RESIDENCE _____

BIRTHDATE: _____

CLINICIAN RESPONSIBLE FOR TREATMENT PROGRAM: _____

- I. DESCRIPTION OF BEHAVIOR:
- II. DESCRIPTION OF TREATMENT PROCEDURES ALREADY
IMPLEMENTED (WITH OUTCOMES):
- III. DESCRIPTION OF OTHER TREATMENT ALTERNATIVES:
- IV. JUSTIFICATION FOR THE USE OF AVERSIVE TREAT-
MENT PROCEDURES:
- V. DESCRIPTION OF TREATMENT PROCEDURE
- VI. DESCRIPTION OF POSSIBLE SIDE EFFECTS:
- VII. SPECIAL PRECAUTIONS TO BE USED IN IMPLEMEN-
TING PROCEDURES:
- VIII. DATA RECORDING PROCEDURES (GIVE BASELINE
DATA):

IX. EXPECTED BEHAVIORAL OUTCOME (ALSO EXPECTED TIME FOR TREATMENT TO BE EFFECTIVE:

X. PERSONS WHO WILL IMPLEMENT TREATMENT PROCEDURES (NAME AND QUALIFICATIONS):

XI. REVIEWED BY (MEMBERS OF SPECIAL COMMITTEE ON AVERSIVE CONDITIONING/HUMAN RIGHTS COMMITTEE/ADVOCATE):

NAMES

SIGNATURES

XII. INFORMED CONSENT

1. a. As legal guardian for this client, I, _____

Name of Legal Guardian

hereby consent to the use of the treatment procedures described on the previous pages in the treatment of

Name of Client

OR

b. (for competent client), I _____, hereby

Name of Client

consent to the use of the treatment procedures described on the previous pages for me.

2. I acknowledge that no guarantees have been made to me regarding the results of this treatment.
3. I understand that within the scope of this treatment there is no intent to cause detrimental side effects to the client.
4. I also understand that the treatment procedure described above will be closely monitored and supervised and in the event of the observation of any detrimental side effects

which might be injurious to the client (see VI, Page 2), the treatment procedures will be immediately terminated. I further understand that the decision to terminate may be made either by myself or by the therapist. However, normally the decision will be made jointly.

5. This form has been fully explained to me and I certify that I understand its contents.

Signature of Person legally authorized to consent for client:

Address _____

City & State _____

Relationship _____

Date

Witness:

Signature _____

Address _____

City & State _____

**The External to Internal shift of controls
as an individual develops maturity.**

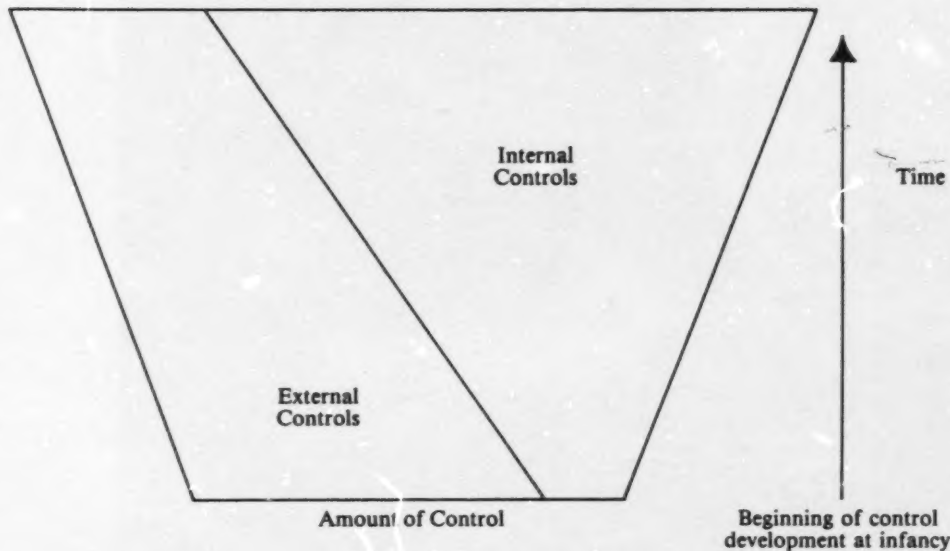


FIGURE #1

**Sample
Preliminary Treatment Plan**

Client Name: John Doe Date: 12/15/83

Case Management Team: BMR Caseworker, Substance Abuse Treatment Counselor, Probation Officer, Home Operator, VR Counselor, Client, Mental Retardation Alcoholism Project Staff.

Case Manager: BMR Caseworker

Presenting Problems:

1. Arrested for Drunk and Disorderly
2. May lose placement at supervised apartments for fighting while intoxicated
3. Reported hospitalization one month ago for seizures (possibly related to failure to take medicine)
4. Can not read or write
5. Unemployed
6. Poor money management skills — BMR is his representative payee
7. No family involvement with client
8. Has several issues related to sexuality

Plan:

1. Outpatient substance abuse counseling two times/week for ½ hour
Rationale: Client demonstrates many substance abuse problems but requires further assessment to determine the extent of the problem
Responsibility: Outpatient Counseling at S.A. Treatment Program, Counselor
2. Medical evaluation records of seizure disorder and general health
Rationale: Previous hospitalization and substance abuse problems
Responsibility: Caseworker will locate records
3. Cassette tapes will be used for alcohol and drug abuse education
Rationale: Cannot read, may refer to Literacy Volunteers at a later date
Responsibility: S.A. Counselor and MRAP staff
4. Vocational Rehabilitation Counseling - will begin service following stabilization of substance abuse problem - this may serve as an incentive for him.
Rationale: Client is not accustomed to a great deal of responsibility at one time, therefore, he may need to integrate it into his life slowly

Responsibility: Team will discuss it at next meeting

5. Integration of family into the substance abuse counseling, at later date
Rationale: Family is hesitant to deal with client, may be willing to be involved in treatment

Responsibility: Client and Counselor will encourage family involvement

6. May need counseling related to his sexual issues, but will put this on hold for the time being.

Rationale: Do not want to overload the client

7. Participation in Alcoholics Anonymous - Home Operator has agreed to transport the client to AA and will help him become comfortable with the people and the meetings. Home Operator feels he can do this for about three weeks. May need to reassess the client's integration into the program at that time

Rationale: Client needs assistance in socialization skills, learning to ask for help and transportation

Responsibility: Home Operator

Case Review: The team will meet in four weeks unless otherwise notified by the case manager.

Client _____

Counselor _____

Case Manager _____

**Sample
Secondary Treatment Plan**

Client Name: John Doe Date: 12/27/83

Case Management Team: See Preliminary Plan

Case Manager: Caseworker

Assessment Completed:

Diagnosis: Moderate substance abuse-primary drug is alcohol

Substance Abuse Treatment Plan:

1. Continue on an outpatient basis and re-evaluate if client has difficulty maintaining sobriety. Client has a short attention span but functions fairly well at 20-30 minutes per session. Will organize some learning exercises to balance with talk therapy. Caseworker will participate at least once every two weeks to begin with. Will also continue to work to bring family into sessions.
2. Continue AA involvement-secure an AA sponsor (Call Home Operator to check on progress at AA).
3. Will tape record one-to-one counseling sessions which focus on education. Client can listen to them 2 to 3 times between each session to reinforce each concept.
4. Home Operator has contracted with the client re: fighting in the apartment.
5. Probation Officer has made sobriety a condition of his probation.
6. One time per month the counselor will meet with the client outside the office to help the client to generalize the information, to see the counselor as a role model outside of the office and to help the client learn alternative recreational activities.
7. Medical records received. Client is on Dilantin and needs education about the effects of combining the medication with alcohol. Counselor will integrate into education sessions.
8. Review this plan every two weeks to evaluate its effectiveness with the client.

Client _____

Counselor _____

Case Manager _____

Sample Aftercare Plan

Client Name: John Doe Date: 1/20/84

Case Management Team: Client, BMR Caseworker, S.A. Counselor, Probation Officer, Home Operator, Vocational Rehabilitation Counselor

Case Manager: BMR Caseworker

Goal Areas: Substance Abuse Treatment	Education/Vocational
Physical Problems	Spiritual
Social/Cultural	Psychological/Emotional

Goal

Learn more about my alcoholic behavior

To live semi-independently

To get a job

Learn to take seizure meds appropriately

Resolve legal issues

Find Alternative recreational activities

Provide support for sobriety within the home

Plan

Outpatient Counseling 2/week for ½ hour each (not appropriate for group counseling) AA participation/ Sponsor obtained in treatment will provide transportation. Client will listen to educational tapes developed in treatment at least once a week

Currently lives in foster home but wants to live in an apartment, Caseworker will explore options and let client know (We may use this as an incentive for following through on the plan).

Re-open case with VR counselor

Learn more about prescription drug abuse with S.A. Counselor, Caseworker will set up a reward system for taking meds appropriately

Report regularly to Probation Officer. Develop a contract with client to remain chemically free while on probation

Ask at AA for suggestions, begin making a list with S.A. Counselor, find 1 new item for the list for each session

Foster family will participate in one counseling session per week for the first month (then will re-evaluate the need)

Areas to be addressed in the future:

1. work on relationship with the family
2. improve socialization skills
3. return to school
4. learn money management skills
5. independent living

Case Management: The Case Manager will monitor the client's progress and contact the team as necessary.

**Sample
Client Contract**

Purpose: To encourage the client to be quiet and listen while others are talking in group growth sessions

I, _____, agree to be quiet and listen to other group members while they are talking. I understand that we all may have our turns and that by listening to others I may learn more about myself. I also understand that if I do interrupt others that the counselor will ask me one time to please be quiet. If I continue to talk the counselor can ask me to leave group. Each day, after the group session is over, the counselor will give me feedback on my behavior in the group.

Client _____

Counselor _____

Date _____

**Sample
Client Contract**

I, _____, agree to the following contract. If I come into the Bureau of Mental Retardation and have been drinking booze or smoking pot, then the BMR staff can refuse to give me my check from S.S.I. However, I also understand that if I come into the Bureau office and I have not been drinking or smoking pot, then I may have my check. I understand that this is being done to help me with my problem with alcohol and drugs. I understand that I may withdraw from this contract at any time but that by withdrawing, it may be harmful to my recovery.

Client: _____

Date: _____

Witnessed and Explained By:

Date: _____

**Sample
Reward System**

Client John Doe Date 1/5/84

Case Manager Mary Smith Client's Age 27 yrs.

Goal: To encourage client to ask for help when he feels depressed

List below some reinforcers for your client

1. Likes to be touched - he is very affectionate
2. Wants to save his money to buy a T.V. but has very poor money management skills
3. Wants to live "on his own"
4. Likes comic books and cigarettes
5. Wants to feel a part of group

Determine which reinforcer would work best to achieve the above stated goals

#1 and #5 above

Are these reinforcers appropriate for the individual's age group? Yes

In what environment will the reward system occur? residential treatment

Plan: Every time he asks for time in group and then uses it, the client can ask for a handshake from a group member. If the client asks for time more than three times in one week, then the client can ask for a hug.

Evaluation Plan on: 1/26/84

Client _____

Caseworker _____

Counselor _____

**Sample
Reward System**

Client Jane Date 5/12/82

Case Manager Karen Client's Age 32 yrs.

Goal: To provide an incentive for the client to attend AA & Counseling

List below some reinforcers for your client

1. Wants control of her money (Mother is her representative payee)
2. Likes to buy clothes
3. To have someone listen to her tell stories of her childhood
4. Likes to ask for hugs but often does so inappropriately

Determine which reinforcer would work best to achieve the above stated goal.

#2

Is this reinforcer appropriate for the individual's age? Yes

In what environment will the reward system occur?

outpatient/client is living with her parents

Plan: Jane's mother has agreed to give Jane \$5.00 a week if she attends at least three AA meetings and goes to her counseling sessions. Jane may spend this money as she wishes (clothes). The Case Manager will monitor the plan.

Evaluation Plan on: 6/12/82

Client _____

Case Manager _____

EDUCATION

Educating the intellectually limited person about alcohol and drug abuse can be a very demanding activity for counselors. You are encouraged to use the assistance of the Bureau of Mental Retardation in determining how much information should be given to the client and what is the best way to present that information.

When assessing the needs of your client and planning the best way to provide alcohol and drug education to your client, four considerations must be taken into account.

1. Maturity
2. Learning skills
3. Social adjustment
4. Actual Age

Is the client mature enough to handle the information you wish to present? Will the client be able to accept and understand the information? For example, some individuals have had very little exposure to sex education. If that were the case, then, the client is not likely to be emotionally prepared for information on how alcohol affects one's sex life. Counselors can generally get a fairly good idea of the client's level of maturity in the counseling sessions. However, it is best to "check it out" with the caseworker if there is one. If not, counselors can present the information to the client slowly and evaluate and respond to the client's reactions.

Learning skills can vary for mentally retarded adults. One thing to keep in mind, however, is that most mentally retarded people do not have the expectancy of reinforcement on a day-to-day basis. In other words, most of us learn that if we act a certain way or accomplish a certain task, that somehow we expect to be reinforced for it, either positively or negatively, and either internally or by external factors.

Mentally retarded people do not necessarily expect any reinforcement or outcome and learning becomes a whole new task for them. This is one reason why building in reinforcers through a goal oriented system is more useful to a mentally retarded person. Other factors such as the ability to read and write must also be considered. Also, is the client able to understand pictorial representations of the material or does the client benefit more from a verbal interchange? Clearly, these are examples of why the individual's learning ability must be assessed prior to planning

educational activities.

Social adjustment is another consideration for planning educational materials. Is the client streetwise or does she or he live in a supervised residence? What is this client's peer group like? Again, does this client lack an expectancy of reinforcement? What is the client's background. Is the client male or female? These are questions we must ask ourselves about the client when determining what information might be most appropriate.

What is the actual chronological age of the client? Is the material appropriate for someone of that age? It is very important to determine whether the information we are providing the client is consistent with his or her age. We do not want to encourage adults to act their age by giving them material for a child. Unfortunately, most existing materials simply do not work. Materials which are already on the market are produced at a level which may not be useful to the client. Therefore, at times it becomes necessary for the development of new materials or the adaptation of existing materials to fit the client's needs.

Things to remember in making your own educational materials for the mentally retarded client.

1. Keep it simple.
2. Repeat the concepts many times throughout the material.
3. When making audio tracks and cassette tapes, speak slowly and clearly.
4. Don't put too many concepts into one piece of material. For example, pick one aspect of alcoholism and talk about it. Too much information at one time can become mind boggling.
5. If the material is printed, use short and simple sentences with a lot of descriptive pictures.
6. Make sure the material is appropriate for the client's age.
7. It is best to share the material with someone from the Bureau of Mental Retardation. They may be helpful in evaluating whether the information is too difficult for the target population.

ALTERNATIVE METHODS FOR PRESENTING EDUCATION MATERIALS

1. One-to-one discussions on a particular topic - remember to ask for feedback from the client, find out if the client really understands the information by asking them to repeat it back to you in their own words, and keep the session short.

Variations can be made on a basic one-to-one educational session such as:

- a. Make a cassette tape recording of the session and ask the client to listen to it 2 or 3 times before your next session.
 - b. Discuss a film that the client has seen recently. It is best to do this immediately after the film to clear up misunderstandings, provide timely reinforcement and to help clients remember new information through repetition.
 - c. Discuss a poster.
 - d. Videotape the session and play it back at the next session.
2. Group Education - if you are working with more than one intellectually limited client, you can use basic group interaction as a way to reinforce ideas, work on socialization skills and in role playing. The use of flip charts, pictures and audio-visual materials, again, can be useful.

ADAPTABLE EDUCATIONAL MATERIALS

Below are some materials which may be used in educating intellectually limited clients about chemical dependency.

1. "Drugs and Decisions", produced by the Milwaukee Council on Drug Abuse, Inc. is a prevention program for mentally retarded persons. However, a good portion of this material can also be used as treatment education. It is designed for high functioning mentally retarded people (mild or moderate retardation) and is appropriate for adolescents as well as adults.
2. Channing L. Bete, Co. provides scriptographic presentations about alcohol and drug abuse geared for all age groups. The sentences are short and clear but sometimes contain terminology which may not be

familiar to the client. Pictorial examples are offered but some are not self explanatory. If the client cannot read or reads at a lower level, this material may best be used as a basis for a discussion about one aspect of chemical dependency. Following are some titles and possible times for their use.

- "About Alcoholism Services" - can be used in an orientation to treatment.
 - "What Everyone Should Know About Alcohol" - prevention or treatment education.
 - "What Everyone Should Know About Alcoholism" - prevention or treatment education.
 - "Drugs and You"
 - "What Every Teenager Should Know About Alcohol"
 - "How to Understand Yourself . . . and Others"
 - "What Everyone Should Know About Mental Retardation" (if the client requests information about this label).
3. NIAAA produces "Should I Drink?" about drinking and pregnancy. The pictures show where the alcohol goes after it enters the body and how it can effect the child.
 4. "Rex Morgan, M.D. Talks . . . About Your Unborn Child" by NCALI is in comic book form and may be best for adolescents.
 5. "It's My Life" by the Alcohol and Drug Addiction Research Foundation of Toronto is designed to help the individual understand themselves better. It is concrete and straightforward. It is designed for school age kids but many of the concepts can be adapted to adult learning.
 6. "This Side Up" printed by NIDA is designed to help adolescents make decisions about drugs. It is not appropriate overall for adults but contains numerous exercises which may be useful in working with intellectually limited clients (for example, the sections on "Getting to Know You" and "It Makes Me Angry".)

APPENDIX D
RESOURCES

DEFINITIONS

Accessibility. Generally, buildings and structures modified to enable persons with limited mobility to move in or about these buildings and structures. Accessibility is a requirement under all federally funded projects.

Adaptive Behavior. The effectiveness with which an individual meets the standards of personal independence and social responsibility expected of his age and cultural group. Three aspects of this behavior are maturation, learning and social adjustment.

Advocacy. Under the D.D. Act, advocacy is a system, independent of service providers, to protect D.D. persons by use of legal, administrative and other remedies. Advocacy can also be one person intervening on the behalf of another, with permission, when the other person is unable to successfully act in his own behalf.

Ambulatory. Able to walk or move about independently.

Aphasia. Partial or total loss of the ability to articulate ideas in any form, resulting from brain damage.

Assessment. Individual evaluation of a person's performance or development which can be used in educational and/or program planning and which may result in special education instruction and services.

Ataxic. Pertaining to loss or lack of muscular coordination.

Athetoid. A condition in which there is a constant, slow involuntary movement, usually an extending and flexing of the fingers and hands.

Autism. A severe disturbance of mental and emotional development that appears in childhood. Symptoms include absent or limited speech, monotonously repetitive body movements, social withdrawal and involvement with inanimate objects rather than people. Autism is not to be confused with mental retardation.

Barrier Free. Building, facility, or area that is completely accessible to persons having mobility problems.

Behavior Disabilities. Socio-emotional disorders manifesting behavioral dysfunction including problems of mental illness, mental retardation, chemical dependency, and related problems.

Behavior Modification. The control of learning environment through a planned systematic application of the principles of learning in shaping an individual's behavior to minimize or eliminate negative behavior and to emphasize and reinforce positive behavior.

Case Management. The coordination of a person's involvement with various agencies/services (making sure a person doesn't get lost in the system).

Competency Test. An evaluation of an individual to determine whether he is legally capable of making choices and legally responsible for his actions; applies to a person with mental illness or mental retardation as well as a minor.

Conservatorship. A limited form of supervision tailored to meet the needs and abilities of a person with a disability. Conservatorship is like guardianship, but persons under a conservatorship retain certain rights.

Coordination. The joining of elements of social-services so that compatibility and cooperation among elements are maximized.

Developmental Disability. A severe, chronic disability of a person which

- is attributed to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the person attains age twenty-two;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
- reflects the person's need for a combination and sequence of special interdisciplinary or generic care treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

Developmental Period. Up to age 22 (see definition of "Developmental Disability.")

Down's Syndrome. A type of mental retardation associated with specific physical characteristics due to a chromosomal abnormality.

Dysfunction. Disordered or impaired function of a bodily system or organ.

Dyslexia. Impairment of the ability to read; a disability characterized by reading, spelling, and various language disabilities, observed in children with normal intelligence who are otherwise, at least, average in academic and social achievement.

Educable. Individuals, usually classified as having mental retardation, who exhibit characteristics that indicate the capability of becoming socially adjusted and economically independent at a minimum level, or persons with mildly retarded mental and adaptive behavior who demonstrate ability to be semi-independent and can learn academic skills near the 6th grade level.

Epilepsy. A disorder of the central nervous system marked by sudden and periodic lapses of consciousness, and distinctive, usually measurable disturbances in the electrical discharges within the brain.

Evaluation. An appraisal or estimation of certain specific characteristics, such as intelligence, personality, physical aspects, or vocational readiness of an individual.

Exceptional. In education, a word used to describe a child whose abilities or intelligence are exceptionally high or low.

Family Foster Care. Care provided by foster parents usually with the supervision and financial support of a child placement agency.

Guardianship. A legal status providing protection, care, and management of a person considered incapable of managing his own affairs.

Group Home. A licensed home with designated substitute parents. Persons who have retardation placed in group and family care homes may participate in special education, vocational or day care facilities in the community.

Handicap. Condition, especially anatomical, physiological, or mental, that prevents or restricts normal achievement. Multiple Handicap - having more than one handicap. Substantial Handicap - physical or mental disability of such severity that, alone or in connection with social, legal or economic constraints, it requires the provision of special services over an extended period of time.

Impaired. Diminished strength, ability or use.

Independent Living Skills. Appropriate behavior necessary for living in a non-institutionalized setting. Skills include transportation, maintenance of clothes and living quarters, personal hygiene, money handling, group living, and recreation.

Institutionalization. The inhibiting and dehumanizing effects on a person's development that results when he is placed in an institution where there is limited sensory stimulation and limited personal experiences.

Institutional Reform. Movement to change institutions so as to eliminate the negative effects mentioned above or modification or improvement of the total institutional environment to ensure maximum individual development in the least restrictive environment possible.

Intermediate Care Facility. (ICF) Facility for persons with mental retardation or related conditions; a facility primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded or have related conditions.

I.Q.. Intelligence Quotient, a numerical rating determined through psychological testing which indicates approximately the relationship of a person's mental age (MA) to his chronological age (CA).

Learning Disability. Any defect in a person's ability to learn one of the basic academic disciplines, or general defect in learning to write, or in learning mathematics in which the cause is not easily determined.

Mainstreaming. The effort to include and keep disabled individuals in the regular school system class structure.

Mental Age. A measure of mental development, determined by intelligence tests expressed as the age at which that level is average.

Mental Retardation. A characteristic which develops early in life and is manifested by a below average rate of learning and social adjustment. There is a wide range within which the learning and social adjustment rates occur.

Mongolism and Mongoloid. Archaic term for Down's Syndrome.

Perceptual Problems. Difficulties in perceiving things, being aware of things, or using the senses, particularly sight and hearing.

Prevention and Early Intervention. System of programs to educate in the prevention of developmental disabilities through early care.

Protective Services. A system of social, legal or other appropriate services which assists individuals unable to manage their own resources or to protect themselves from neglect, exploitation, or hazardous situations without assistance from others.

Psychotic. Relating to a mental disorder causing distortion or disorganization of a persons' mental capacity.

Residential Facility. A facility or residential program which provides housing and appropriate supervision for individuals requiring development or behavioral assistance on a 24-hour basis outside the individual's home.

Respite Care. Short term, temporary care of a person with a developmental disability so the persons' family can take a vacation or handle a family crisis.

Seizure. A lapse or impairment of consciousness originating in the brain. A seizure may be accompanied by abnormal motor and sensory functions.

Sheltered Employment. A structured program providing partial self-support through the employment of the handicapped worker under conditions which allow a reduced production rate, special work supervision, limited job duties, or special job engineering, training and adaptive equipment.

Sheltered Workshop. A facility that provides individuals who are not able to work in competitive employment with an opportunity to train and work in a controlled environment at their level of functioning.

Slow Learner. A child with social and academic behavior less than usual age level standards.

Special Education. Educational services provided for exceptional children who deviate physically, mentally, or socially from the regular class so that the standard curriculum is not suitable for their educational needs.

Trainable. A person with moderate or severe retardation who has very limited potential for independent living and who achieves a minimum of

academic skills.

Treatment. Provision of specific physical, social, or mental interventions which halt, control or reverse processes which cause, aggravate, or complicate malfunctions or dysfunctions.

These preceding definitions were taken from "A Writer's Reference to Developmental Disabilities" published by the Developmental Disabilities Planning Office.

Types of Services for Mentally Retarded People

Mentally retarded adults who live in the community have access to a variety of day programs, depending on their needs and abilities. These programs generally operate during normal work hours, Monday through Friday. Access to the programs may be had by referral through the regional office to the Bureau of Mental Retardation or by direct referral to the program.

1. FUNDAMENTAL LIFE ACTIVITIES

The purpose of this program is to offer training and services which focus primarily upon behaviors and activities which are basic to self-maintenance, self-awareness and self-motivation and which address psycho-social, sensory motor and physiological needs of individuals within a developmental range of 0-3 years.

2. PRACTICAL LIFE ACTIVITIES

The purpose of this program is to offer training and services which promote the practical and useful application, adaptation and integration of developmental skills necessary for semi or independent daily living.

3. PERSONAL/SOCIAL/INDEPENDENT LIVING SKILLS

The purpose of this program is to offer training and services which are designed to develop or modify a wide range of individual skills and behaviors in personal and social adjustment and community living skills, based upon socially appropriate individual or group behaviors.

4. WORK ACTIVITIES

The purpose of this program is to offer training and services which are designed to maximize individual functioning in personal development and community living, and to provide a regular program of work experience at an introductory level.

5. WORK ADJUSTMENT TRAINING

The purpose of this program is to offer training and services which provide a substantial and remunerative work experience which is designed to promote the acquisition of good work habits and skills, to increase physical and emotional tolerance to work, to improve work related skills

and to modify attitudes and behaviors which inhibit satisfactory work performance.

6. SHELTERED EMPLOYMENT

The purpose of this program is to offer training and services which focus primarily upon work and remunerative employment of a continuous nature for individuals who are not capable of functioning in a competitive work force, within an environment which reduces the pressures of competitive employment.

7. VOCATIONAL SKILLS

The purpose of this program is to offer training and services which focus upon an identifiable vocation or occupation and to develop the specific skills which are necessary to perform such a vocation or occupation.

8. VOCATIONAL EVALUATION

The purpose of this program is to gather, interpret, analyze and synthesize all vocationally significant data, that is, medical, social, psychological, that have been collected regarding an individual and relating them to occupational requirements and opportunities.

A number of community residential alternatives are available to mentally retarded persons. Through its Individual Program Plan service and social service staff, the regional offices of the Bureau of Mental Retardation assists in the appropriate referral of clients to that residential setting which is the least restrictive, provides a suitable living environment, and is most conducive of personal development.

1. SUPERVISED APARTMENTS

An independent living program which provides apartment accommodations, usually located within one building. Twenty-four hour availability of staff support provides ongoing training in housekeeping, personal hygiene, budgeting, nutrition and utilization of community resources.

2. FOSTER CARE

A licensed or approved family home in which a child or adult is given the opportunity to develop maximum potential through experiences in a family setting and participation in community life.

3. FOOD AND LODGING

A facility which provides for common living and dining areas. No residential programming is offered and these facilities are not established to specifically serve mentally retarded persons.

4. BOARDING HOME

A home engaged in providing personal care, supervision and training to three or more mentally retarded persons sixteen years of age or older.

5. GROUP HOME

A home which is similar to a boarding home, but usually is operated by a non-profit agency and provides a structured residential program, organized community interaction and a high staffing pattern.

6. INTERMEDIATE CARE FACILITY FOR MENTALLY RETARDED (ICF/MR) - Nursing and Group

A home which is licensed under state law to provide care and active treatment to mentally retarded persons who require a level of care and treatment available in boarding or group homes.

ICF/MR Nursing - Homes which are provided for persons who require nursing services.

ICF/MR Group - Homes which are provided for persons who do not require nursing services.

Please keep in mind that these services are for mentally retarded people. Generally, they are not appropriate for higher functioning clients. In fact, it may be more harmful to "group" a high functioning client with lower functioning mentally retarded people. If you have a question regarding these services, you may contact the Bureau of Mental Retardation.

CHAPTER 186-A

RIGHTS OF MENTALLY RETARDED PERSONS

§ 2141. Legislative intent and findings; rights of mentally retarded persons.

1. **Articulation of rights.** It is the intent of the Legislature to articulate rights of mentally retarded persons, so that these rights may be exercised and protected. Each mentally retarded person shall have all the rights enjoyed by citizens of the State and of the United States, unless some of these rights have been suspended as the result of court guardianship proceedings.
2. **Normalization.** The Legislature finds and declares that the rights of mentally retarded persons can be protected best under a system of care which operates according to the principles of normalization. The Legislature further finds and declares that the system of care for the mentally retarded citizens of the State shall operate according to these principles with the goals of:
 - A. Continuing the development of community-based services which provide reasonable alternatives to institutionalization in settings that are least restrictive to the client; and
 - B. Providing habilitation, education and other training to mentally retarded persons which will maximize their potential to lead independent and productive lives and which will afford opportunities for outward mobility from institutions.
3. **Intent of act.** It is the clear, unequivocal intent of this Act to guarantee individual dignity, liberty, pursuit of happiness and the protection of the civil and legal rights of mentally retarded persons.

§ 2142. Definitions

As used in this chapter, unless the context otherwise indicates, the following words shall have the following meanings.

1. **Bureau.** "Bureau" means the Bureau of Mental Retardation of the Department of Mental Health and Corrections.
2. **Client.** "Client" means any mentally retarded person receiving services from the bureau or from an agency or facility licensed or funded to provide services to mentally retarded persons, except those pre-

seintly serving sentences for crime.

3. Day facility. "Day facility" means any nonresidential facility owned, operated, licensed or funded, in whole or in part, by the department or through the Department of Human Services.
4. Department. "Department" means the Department of Mental Health and Corrections.
5. Express and informed consent. "Express and informed consent" means consent voluntarily given with sufficient knowledge and comprehension of the subject matter involved so as to enable the person giving consent to make an understanding and enlightened decision, without any element of force, fraud, deceit, duress or other form of constraint or coercion.
6. Habilitation. "Habilitation" means the process by which an individual is assisted to acquire and maintain those life skills which enable him to cope with the demands of his own person and environment; to raise the level of his physical, mental and social efficiency; and to upgrade his sense of well-being. It includes, but is not limited to, programs of formal, structured education and treatment.
7. Normalization principle. "Normalization principle" means the principle of letting the mentally retarded persons obtain an existence as close to normal as possible and making available to them patterns of the mainstream of society.
8. Residential facility. "Residential facility" means a facility providing 24-hour residential care for mentally retarded persons which is owned, operated, licensed or funded, in whole or in part by the department or through the Department of Human Services.
9. Treatment. "Treatment" means the prevention, amelioration or cure of a patient's physical and mental disabilities or illness.

§ 2143. Rights and basic protections of mentally retarded clients

1. Humane care. Clients shall have the right to dignity, privacy and humane care.
2. Practice of religion. Clients shall have the right to religious freedom and practice. Nothing shall restrict or force infringement on a client's

right to religious preference and practice.

3. Communication. Clients shall have a right to private communications:

A. Each client shall be allowed to receive, send and mail sealed, unopened correspondence. No person who owns or is employed by a day facility or a residential facility shall delay, hold or censor any incoming or outgoing correspondence of any client; or open any such correspondence without the consent of the client or his legal guardian;

B. Clients in residential facilities shall be afforded reasonable opportunities for telephone communication; and

C. Clients shall have an unrestricted right to visitations during reasonable hours. Nothing in this provision shall be construed to permit infringement upon other clients' rights or privacy.

4. Work. Clients engaged in work programs which require compliance with state and federal wage and hour laws shall be provided with fair compensation for labor in compliance with regulations of the United States Department of Labor.

5. Vote. No client shall be denied the right to vote, unless under guardianship, for reasons of mental illness as provided in the Constitution of Maine, Article II, section 1.

6. Personal property. Each client shall have the right to the possession and use of his own clothing, personal effects and money. When necessary to protect the client or others from imminent injury, the chief administrator of the day facility or a residential facility may take temporary custody of clothing or personal effects which shall be immediately returned when the emergency ends.

7. Nutrition. Each client in a residential facility shall have the right to nutritious food in adequate quantities. Meals shall not be withheld for disciplinary reasons.

8. Medical care. Each client shall have the right to receive prompt and appropriate medical and dental treatment and care for physical and mental ailments and for the prevention of any illness or disability. Medical treatment shall be consistent with the accepted standards of medical practice in the community, unless the religion of the client

prohibits.

- A. Medication shall be administered only at the written order of a physician. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a habilitation plan or in unnecessary or excessive quantities.
- B. Daily notation of medication received by each client in a residential facility shall be kept in the client's records.
- C. Periodically, but no less frequently than every 6 months, the drug regimen of each client in a residential facility shall be reviewed by the attending physician or other appropriate monitoring body, consistent with appropriate standards of medical practice. All prescriptions shall have a termination date.
- D. Pharmacy services at each residential facility operated by the department, shall be directed or supervised by a professionally competent pharmacist licensed according to the provisions of Title 32, chapter 41.
- E. Prior to instituting a plan of experimental medical treatment or carrying out any surgical procedure, the express and informed consent shall be obtained from the client, unless the client has been found to be legally incompetent, in which case the guardian of the client's person may consent. Information upon which the client shall make necessary treatment and surgery decisions shall include, but not be limited to:
 - (1) The nature and consequences of such procedures;
 - (2) The risks, benefits and purposes of such procedures; and
 - (3) Alternative procedures available.
- F. The express and informed consent of a person described in paragraph E may be withdrawn at any time, with or without cause, prior to treatment or surgery.
 - (1) Notwithstanding the absence of express and informed consent, emergency medical care or treatment or surgical procedures may be provided to any client who has been injured or who is suffering from an acute illness, disease or condition if delay in initiation

of emergency medical care, treatment or surgery would substantially endanger the health of the client.

- (2) The absence of express and informed consent notwithstanding emergency medical care or treatment to any client who has been injured or who is suffering from an acute illness, disease or condition may be provided if, within a reasonable degree of medical certainty, delay in initiation of emergency medical care or treatment would endanger the health of the client.

9. Social activity. Each client shall have the right to have suitable opportunities for behavioral and leisure time activities which include social interaction.
10. Physical exercise. Each client shall have the right to have opportunities for appropriate physical exercise, including the use of available indoor and outdoor facilities and equipment.
11. Discipline. No client shall receive inhumane discipline. Each facility shall prepare a written statement of policies and procedures for the control and discipline of residents which is directed to the goal of maximizing the growth and development of the clients and copies of this statement shall be given to each client and parent or legal guardian of each client, if the client has been adjudged incompetent and shall be posted in each residential and day facility.
- A. Residents shall participate, as appropriate, in the formulation of such policies and procedures.
- B. Corporal punishment shall not be permitted.
- C. Seclusion, defined for the purposes of this chapter as the placement of a resident alone in a locked room for a period in excess of one hour, shall not be employed. Placement of a resident alone in a locked room for a period of less than one hour may occur only in emergencies to protect the client or others from imminent injury, provided a client so placed shall be visually checked by a staff person at 10-minute intervals throughout the duration of such placement.
12. Behavior modification. No client shall be subject to a treatment program to eliminate bizarre or unusual behavior, without first being examined by a physician to rule out the possibility that such behaviors

are organically caused. Treatment programs involving the use of noxious and painful stimuli may only be employed to correct behavior more harmful to the client than the treatment program on the recommendation of a physician or psychologist and with the approval, following a case-by-case review, of the chief administrator of the residential facility and a client advocate of the department.

13. Physical restraints. Clients shall have the right to be free from physical restraints. Physical restraints shall be employed only in emergencies to protect the client from imminent injury to himself or others. Restraints shall not be employed as punishment, for the convenience of staff, or as a substitute for habilitative services. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the client and shall be designed to allow the greatest possible comfort.

A. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered restraints, but shall be prescriptively designed and applied under the supervision of a qualified professional with concern for principles of good body alignment, circulation and allowance for change of position.

B. Totally enclosed cribs and barred enclosures shall be considered restraints.

C. Daily reports on the use of restraints shall be made to the appropriate chief administrator of the facility. A monthly summary of such reports shall be relayed to the Office of Advocacy. The reports shall summarize all such cases of restraints, the type used, the duration of usage and the reasons thereof.

14. Records. All client records shall remain confidential as provided for in section 1-B. The client, or his parent or legal guardian if the client is incompetent, shall have access to records upon request. The department shall have access to the records of a day facility or a residential facility as may be necessary to carry out the statutory functions of the department.

§ 2144. Violations; liability for violations

1. Violations reported and investigated. Any alleged violation of a client's rights shall be reported immediately to the Office of Advocacy

of the department and to the Attorney General's office. The Office of Advocacy shall conduct an investigation of each alleged violation pursuant to the provisions of section 1-A. This office shall submit a written report of the findings and results of the investigation to the chief administrative officer of the facility in which the client's rights were allegedly violated and to the commissioner of the department within 2 working days after the occurrence of discovery of the alleged incident.

2. Liability for violations. Any person who violated or abuses any rights or privileges of clients provided by this Act shall be liable for damages as determined by law. Good-faith compliance with the provisions of this Act in connection with evaluation, admission, habilitation programming, (sic) education treatment or discharge of a client shall be a defense to an action for civil or criminal liability under this Act. Intentional violation of the provisions of this Act shall be punishable as a Class E crime, punishable by imprisonment not to exceed 6 months or a fine as provided in Title 17-A, section 1301. Civil damages may be awarded for negligent or intentional violations of this Act.

§ 2145. Notice of rights

Each client and parent or legal guardian of each client, if the client has been adjudged incompetent, shall promptly receive from the Department of Mental Health and Corrections a written copy of this Act and of section 1-B. Each client shall be promptly informed in clear language of the legal rights of mentally retarded persons. A copy of this Act shall be posted in each residential day facility.

§ 2146. Client government

Upon request of a client, a residential facility shall initiate and develop a program of client government to hear the views and represent the interests of all clients served by the facility. The client government shall be composed of residents elected by other residents and staff advisors skilled in the administration of community organizations. The client government shall work closely with the bureau and the Office of Advocacy to promote the interests and welfare of all residents in the facility.

§ 2147. System of care for mentally retarded clients

1. System of Care. The Legislature declares that the system of care, through which the State provides services to and programs for mentally retarded persons, shall be designed not only to protect the integrity

of the legal and human rights of these persons, but also to meet the needs of these persons.

2. Responsibilities of the department. To facilitate the development of a system which meets the needs of mentally retarded persons the department, through the bureau, shall:

- A. Provide a mechanism for the identification, evaluation, treatment and reassessment of and the provision of services to mentally retarded persons. This mechanism shall include an habilitation program for every client served by the department;
- B. Divert mentally retarded persons from institutional care, whenever professional diagnosis and evaluation, the personal preferences of the client or his legal guardian, and the availability of appropriate services indicate that these persons should be placed in community environments and programs;
- C. Provide programs, so far as resources permit, for the proper habilitation and treatment of mentally retarded persons, which shall include, but need not be limited to, comprehensive medical care, education, recreation, physical therapy, training, social services and habilitation and rehabilitation services suited to the needs of the individual regardless of age, degree of retardation or handicapping condition. No mentally retarded person shall be deprived of these enumerated services by reason of inability to pay;
- D. Work toward effectuating the normalization principle through the establishment of community services for the mentally retarded person as a viable and practical alternative to institutional care at each stage of individual life development. If care in an institutional facility becomes necessary, it should be in the least restrictive setting, consistent with the proper care of the mentally retarded person;
- E. Eliminate its own duplicative and unnecessary administrative procedures and practices in the system of care for mentally retarded persons and encourage other departments to do the same; and clearly define areas of responsibility in order to economically utilize present resources;
- F. Strive toward having a sufficient number of personnel who are qualified and experienced to provide treatment which is beneficial to the mentally retarded clients; and

G. Encourage other departments to provide to mentally retarded persons those services which are required by law. In particular, the department shall:

(1) Work actively to ensure that its mentally retarded clients, as provided for in Title 20, chapter 404, shall receive education and training services beginning at age 6 regardless of the degree of retardation, or accompanying disabilities or handicaps;

(2) Advise the Department of Human Services about standards and policies pertaining to administration, staff, quality of care, quality of treatment, health and safety of clients, community relations and licensing procedures and other areas which affect mentally retarded persons residing in facilities licensed by the Department of Human Services; and

(3) Inform the Joint Standing Committee on Health and Institutional Services of the Legislature about areas where increased cooperation by other departments is necessary in order to improve the delivery of services to mentally retarded persons.

3. Plan. The department, through the bureau, shall prepare a plan, subject to the following provisions:

A. The plan shall indicate the most effective and efficient manner in which to implement services and programs for mentally retarded persons, while safeguarding and respecting the legal and human rights of these persons;

B. The plan shall be prepared biennially and shall be submitted to the Joint Standing Committee on Health and Institutional Services of the Legislature by no later than January 15th of every odd-numbered year; and

C. The committee shall study the plan and shall make recommendations to the Legislature with respect to funding improvements in programs and services to mentally retarded persons.

(P.L. 1977, c. 464)

Articles and books listed in the Bibliography can be located at the State Library in Augusta. Many local libraries have an exchange program with the State Library. Check with them, your local library may be able to locate the information for you. Most references to substance abuse can be obtained through the Maine Alcohol and Drug Abuse Clearinghouse. You may call them at 1-800-322-5004 and they will mail the information to you. The Prevention Programs entitled "Drugs and Decisions" is available through the Milwaukee Council on Drug Abuse.

BIBLIOGRAPHY

Anderson, Pete, "Alcoholism and the Spinal Cord Disabled: A Model Program"

Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

Anderson, Pete, and Alan Lowenthal, "Network Development: Linking the Disabled Community to Alcoholism and Drug Abuse Programs"

Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

Buscaglia, Leo, **The Disabled and Their Parents: A Counseling Challenge.** New Jersey, Charles B. Slack, Inc., 1975.

Boros, Alexander, "Alcoholism Intervention for the Deaf."

Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

Craft, M., Jenkins, Villa - Landa C. "Alcoholism and the Subnormal." *British Journal of Addiction*, 1968, 63, 171-176.

DeBoer, Ronald P. and Gary Rasmussen, "Alcohol and Drug Use Among Clients at a Residential Vocational Rehabilitation Facility."

Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

DiNitto, Diana M. and Curtis H. Krishef, "Alcohol Abuse Among Mentally Retarded Individuals."

Mental Retardation. Vol. 19, No. 4 (August 1981).

Edgerton, R.B., **Cloak of Competence: Stigma in the Lives of the Mentally Retarded.** Berkley, University of California Press, 1967.

"Emotions Anonymous: Counseling and Mentally Retarded Substance Abuser."

Alcohol and Health Research World. Vol. 5, No. 2 (winter 1980/81).

Gale, James L. and Ruth E. Little, "Epilepsy and Alcoholism."
Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

Glass, Edward J., "Problem Drinking Among the Blind and Visually impaired."

Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

"Group Treatment of the Mentally Ill Substance Abuser."

Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

Hepner, Randi, Hal Kirshbaun and David Landes, "Counseling Substance Abusers with Additional Disabilities: The Center for Independent Living."

Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

National Center for Alcohol Education, The Power of Positive Thinking. "Double Trouble: Mixing Drinks with Other Drugs."

Under Grant No. Adm 281-75-0013 for the NIAAA, DHEW, 1977.

Nelson, Norma E., "The Mentally Retarded: Treatment Problems and Solutions." **Social Casework: The Journal of Contemporary Social Work** (January, 1983).

"New Programs for the Mentally Retarded." **Addiction Intervention with the Disabled Bulletin**.

Edited by Alexander Boros. Department of Sociology. Vol. 3, No. 3 (summer of 1982).

Reiss, Steven, Grant Levitan, Richard McNally. "Emotionally Disturbed Mentally Retarded People: An Underserved Population."

American Psychologist. Vol. 27, No. 4. (April 1982).

Reiss, Steven, Grant Levitan and J. Szyszko, "Emotional Disturbance and Mental Retardation: Diagnostic Overshadowing." **American Journal of Mental Deficiency**.

Selan, Bella, "In a Bar Retarded Persons are Idiots No More." Paper presented at the Center for Alcohol and Other Drug Studies Training Institute, Wausau, Wisconsin (February 1979).

Selan, Bella H. "Psychotherapy with the Developmentally Disabled." **Health and Social Work**, 1975, 1, 73-85.

Sengstuck, W.L. Vergasen, G.A. and Sullivan M.M.
"Considerations and issues in a drug abuse program for the mentally retarded. **Education and Training of the Mentally Retarded**. 10, 3, 1975, 138-143.

Stephens E. "Defensive Reactions of Mentally Retarded Adults."
Social Casework. Vol. 34, (1953).

"Together? Disability, Drugs and Alcohol."
Accent on Living. (Spring 1982).

Weiner, Harvey and Sonja Fox, "Cognitive-Behavioral Therapy with Substance Abusers," **Social Casework: The Journal of Contemporary Social Work**, Vol. 63. (November 1982).

Wenc, Frank, "The Developmentally Disabled Substance Abuser."
Alcohol Health and Research World. Vol. 5, No. 2 (winter 1980/81).

Wolfensberger, Wolf, **Normalization** Tornado: National Institute of Mental Retardation, (1972).

**REGIONAL OFFICES
BUREAU OF MENTAL RETARDATION**

REGION I (Aroostook County)

P.O. Box 1285

Presque Isle, ME 04769

764-4104

REGION II (Penobscot, Washington, Hancock Counties)

106 Pine Street

Bangor, ME 04401

942-7326

REGION III (Somerset, Kennebec Counties)

9 Green Street

State House Station 60

Augusta, ME 04333

289-2205

REGION IV (Franklin, Oxford, Androscoggin Counties)

618 Main Street

Lewiston, ME 04240

784-9155

REGION V (York, Cumberland Counties)

169 Lancaster Street

Portland, ME 04101

774-8246 or 774-8248

**REGION VI (Segadahoc, Lincoln, Nox, Waldo Counties plus
Brunswick & Freeport)**

189 Main Street

Thomaston, ME 04861

354-8766

A COOPERATIVE EFFORT BY
THE MAINE DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION
KEVIN W. CONCANNON, COMMISSIONER
AUGUSTA, MAINE
AND
THE KENNEBEC VALLEY REGIONAL
HEALTH AGENCY
DAVID N. FENTON, DIRECTOR
WATERTVILLE, MAINE